

061403 JUL 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. There please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20019

1. DECEASED NAME (TYPE OR PRINT) DR H. Melvin KXX Radlman			2a. DATE OF DEATH MONTH DAY YEAR 7 26 87		2b. HOUR 11:30 A M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 24 05		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEBRASKA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEBRASKA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital of Baltimore		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician		
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN RADMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA UNKNOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NUMBER 9859 220-46-9688		13e. STREET ADDRESS / ZIP CODE 3601 Clark Lane 21215		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NUMBER 9859 220-46-9688		13e. STREET ADDRESS / ZIP CODE 3601 Clark Lane 21215		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOpulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Leilani Gyening M.D.				22c. DATE SIGNED 7/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leilani Gyening				22e. ADDRESS SINAI HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/27/87		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD		23e. DATE REC'D. BY REGISTRAR JUL 31 1987		23f. REGISTRAR'S SIGNATURE Julia Fisher-Randall	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215					

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JUL 31 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR		Item 6 Film G629 SB		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		87 REG. NO. 20020	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
John Francis Rahll		Rahll		7 14 87		11:10 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
M	Caucasian	10 13 1902		85 84 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Balto. Co.	USA			Baltimore City MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Balto. City	Good Samaritan Hospital		Waiter		Miller Bros.		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
MD		Balto. City		4406 Raspe Ave., Balto. 21206			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		17. INFORMANT ADDRESS			
John		Clara		Harry L. DeMOss, 4406 Raspe Ave., Balto. 21206			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		213-03-6494					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							10 min.
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Cardiomyopathy</u>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Repeted Myocardial Infarctions.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
none		none					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Melkon H. Azarian M.D.						7/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
MELKON HASINAZAKIAN		Good Samaritan Hosp. 5601 Loch Raven Blvd.					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN STATE		
Burial		7-16-87	Gardens of Faith		Balto., MD		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John C. Miller, Inc., 6415 Belair Rd. 21206				JUL 15 1987		Julia Davidson-Randall	

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JUL 1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) SHIRLEY FIRST RAINESS LAST					2a. DATE OF DEATH MONTH 7 DAY 1 YEAR 1987 HOUR 8 MIN 30 AM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 4 DAY 29 YEAR 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7b. HOUR 8 MIN 30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL OF BALTO				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN OWINGS MILLS					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8-C HIAWATHA CT/21117		
14. FATHER'S NAME FIRST SAMUEL MIDDLE MISKIN LAST MISKIN					15. MOTHER'S MAIDEN NAME FIRST RACHEL MIDDLE UNKNOWN LAST UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 632-01-3613		17. INFORMANT MAX RAINESS ADDRESS APT. C 8 HIAWATHA CT. OWINGS MILLS, MD 21117					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LYMPHOMA DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/21 19 87 , to 7/1 19 87 , that (I) (we) last saw the deceased alive on 7/1 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harold Shumkhan MD DEGREE MD					22c. DATE SIGNED 7/1/87			22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD SHUMKHAN	
22e. ADDRESS SINAI HOSPITAL OF BALTO									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 2, 1987		23c. NAME OF CEMETERY OR CREMATORY CHEVRA AHAVAS CHESED		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTO. MD			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215					25a. DATE REC'D BY REGISTRAR JUL 08 1987		25b. REGISTRAR'S SIGNATURE Julia Friedman-Padellaro		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20022

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PETRONELE RAKAUSKAS			2a. DATE OF DEATH MONTH DAY YEAR 7 4 87		2b. HOUR 4:25 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11/02/97	6. AGE (IN YEARS LAST BIRTHDAY) 89	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lithuania	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress	12b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg.	
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Jonas Barkaitis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marcele Usas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-34-3224	17. INFORMANT ADDRESS Jonas Rakauskas, 2827 Georgetown Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Insufficiency					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					(b) _____ (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, Coronary artery disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 06/26, 1987 to 07/04, 1987 , that (I) (we) (us) saw the deceased alive on 07/04, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Sabah A. Al-Attar		DEGREE M.D.		22c. DATE SIGNED 07/04/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sabah A. AL-Attar		22e. ADDRESS St. Agnes Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/7/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.,		ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR JUL 06 1987	
				25b. REGISTRAR'S SIGNATURE Julia Benson-Randall	

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SECTION 1

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20023

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	MONTH	DAY	HOURS
RANDALL			JUNE 25 1987			11:30 M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
MALE	BLACK	MONTH	DAY	YEAR	YRS.	MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND		U.S.A.				BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE		SINAI HOSPITAL						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD			BALTO		BALTO		13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST	17. INFORMANT ADDRESS		
BRIAN		RANDALL	WENDY		DEWINE	SCOTT		
16b. SOCIAL SECURITY NO.			17. ADDRESS					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

IMMATUREITY

DUE TO, OR AS A CONSEQUENCE OF

(b)

Prolonged rupture of membrane 98 hours

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

ABRUPTED PLACENTA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
Daniel C. Chazem m.			6/25/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
DANIEL C. CHAZEM M.D.		7320 FARLISON BLVD BALTIMORE MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
	6-29-87	SINAI HOSPITAL	BALTO MD
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
SINAI HOSPITAL 2401 W. BELLEVUE AVE		JUL 28 1987	
25b. REGISTRAR'S SIGNATURE			
Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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061271 JUL 30 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20024

1. DECEASED NAME (TYPE OR PRINT) EMMA		FIRST MIDDLE LAST Randolph		2a. DATE OF DEATH MONTH DAY YEAR 7 27 87		2b. HOUR 1050 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 26 00		6. AGE (IN YEARS LAST BIRTHDAY) 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lafayette Square Nursing Con.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Palmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Waddy		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. 217-01-5703	
17. INFORMANT Charles Palmer Jr.		ADDRESS Kilmonastich Rd.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cordio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prob Cordiac Arrhythmias DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 D.M. HTN. PVD. CHA - AKA.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR (A.M.) MONTH DAY YEAR 1050 P.M. 7-27-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/1/85 to 7/27/87, that (I) (we) lost saw the deceased alive on 7/27/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Mohammed Aslam M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MOHAMMAD ASLAM. M.D.		22e. ADDRESS 300-ARMORY PLACE BALTO MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-31-87		23c. NAME OF CEMETERY OR CREMATORY Palmer Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kilmonastich VA	
24. FUNERAL DIRECTOR NAME William C. Brown		ADDRESS 1206 W. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 29 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

081571 JUL 30 84

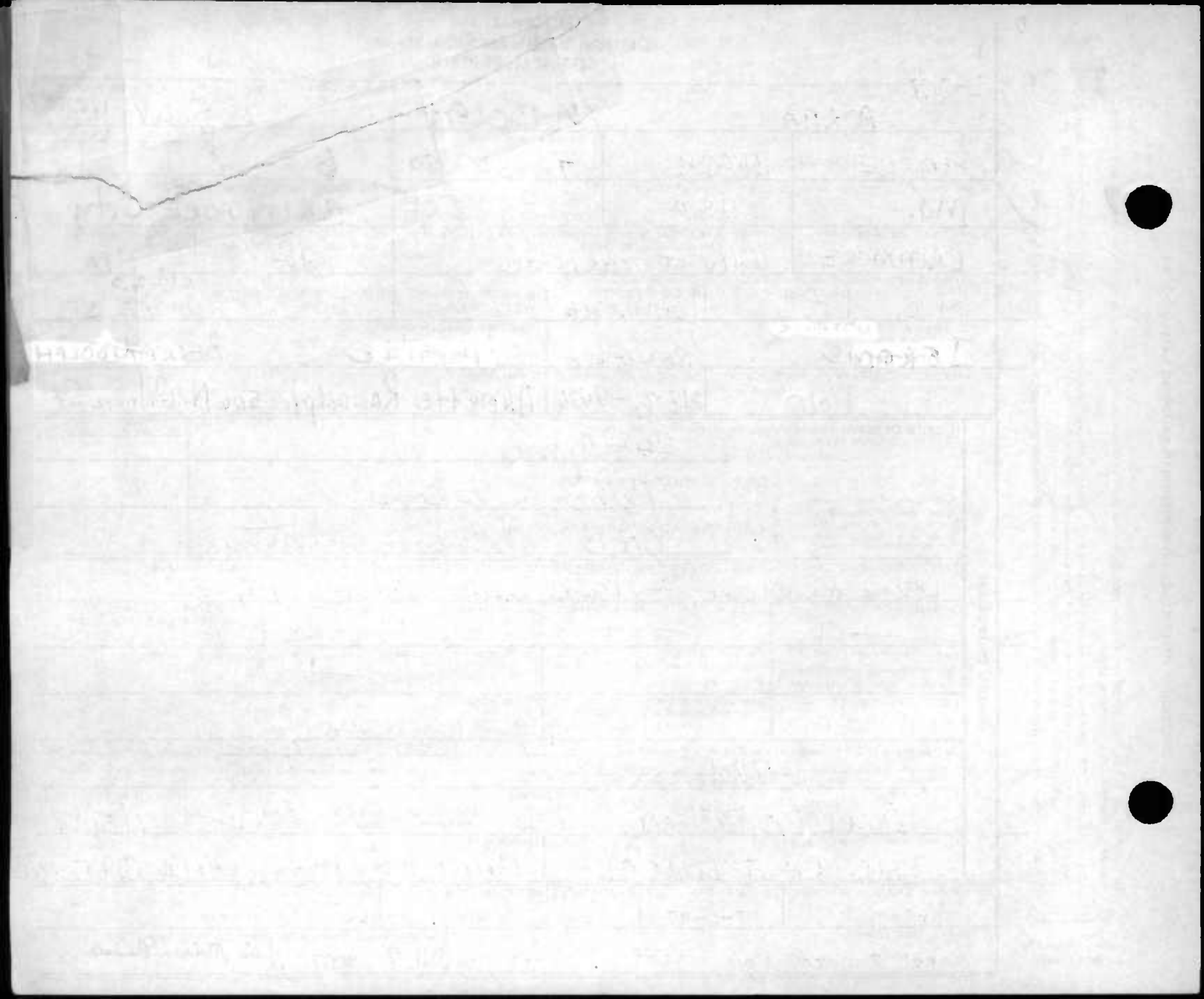
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) PORTIA RANDOLPH									
2a. DATE OF DEATH MONTH DAY YEAR 2002 5 7 5 87 1:27 PM									
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7 30 80		6. AGE (IN YEARS LAST BIRTHDAY) 6 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV OF MARYLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE M.D.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 506 N GILMORE ST. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Jerome RANDOLPH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annette BECOAT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-96-9436		17. INFORMANT ADDRESS Annette Randolph 506 N. Gilmore St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Card Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (c) CAD / Pulmonary Hypertension									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Drum Syndrome, Atrial Defect Pulmonary HT.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NO INJURY					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE NO INJURY					
22a. I certify that (I) (this hospital) attended the deceased from 6/7 19 87 , to 7/5 19 87 , that (I) (we) last saw the deceased alive on 7/5 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eric Castellucci				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERIC CASTELLUCCI				22e. ADDRESS UNIV OF MARYLAND, BALT. MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-9-87		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Home 1101 E. North Ave				25a. DATE REC'D. BY REGISTRAR JUL 7 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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059831 JUL 17 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 REG. NO. 20020
20. DATE OF DEATH MONTH DAY YEAR 07-15-87 2b. HOUR 12:35pm

1. DECEASED NAME (TYPE OR PRINT) Frank Joseph Rasinski		20. DATE OF DEATH MONTH DAY YEAR 07-15-87		2b. HOUR 12:35pm
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 10 22 15	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	7. UNDER 1 YEAR MONTHS DAYS 71
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairmount Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Longshoreman	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Hipolite Rasinski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Navy	17. INFORMANT ADDRESS 21231		
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Navy		17. INFORMANT ADDRESS 21231		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of the Lungs with Metastases		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>C. J. Rasinski</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7-15-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-18-87	23c. NAME OF CEMETERY OR CREMATORY Holy Rosary	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.		25a. DATE REC'D. BY REGISTRAR JUL 16 1987	25b. REGISTRAR'S SIGNATURE <i>Julia D. R. R. R.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit must be given to the funeral director. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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061138 JUL 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 200027

1. DECEASED NAME (TYPE OR PRINT) Ethel Raymond			2a. DATE OF DEATH MONTH DAY YEAR 7/27/87			2b. HOUR 12			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 6 25 09		6. AGE (IN YEARS LAST BIRTHDAY) 78		6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Oliver Wilson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK			15a. STREET ADDRESS / ZIP CODE 501 Dolphin St Apt 1210 21219			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 2-4-16-9148		17. INFORMANT Honay Raymonds		17. ADDRESS 1228 W. YERSON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Sepsis Above knee amputation									
19a. DATE OF OPERATION Before 8/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gramprene of leg				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/27/87 19 87 , to 7/27/87 19 87 , that (I) (we) lost saw the deceased alive on 7/27/87 19 87 , and that in (my) (our) opinion death occurred on the date one hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Dr. M. D. Y				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. M. D. Y				22e. ADDRESS Liberty Med Center					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/31/87		23c. NAME OF CEMETERY OR CREMATORY MT Zion		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD			
24. FUNERAL DIRECTOR NAME ADDRESS Marshall P. Hayes 638 N. Gilman St				25a. DATE REC'D. BY REGISTRAR JUL 28 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbonpapers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

061138 JUL 29 87

061325 JUL 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20028

1. DECEASED NAME (TYPE OR PRINT) Elizabeth			2a. DATE OF DEATH MONTH DAY YEAR 07/25/87			2b. HOUR 1⁰¹ am			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 05 10 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lafayette Square Nursing Ctr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE Maryland		13b. COUNTY Baltimore City		13c. CITY OR TOWN Baltimore City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3463 Hickory Ave. 21211	
14. FATHER'S NAME FIRST MIDDLE LAST William Stoddard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Place					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 176-10-1565		17. INFORMANT ADDRESS Maxine Quigy 2nd Avenue Johnsonburg, PA.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

ASHD

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**IMMEDIATE****MANY Years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

CHF, CBS, Hiatus Hernia.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 7-23-19-77 to 7-25-19-87 , that (I) (we) last saw the deceased alive on 7-24-19-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE S. Khan		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-25-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHANKAR Y. KHAN		22e. ADDRESS 1521 KING WILLIAM DR. BALTO. MD 21228					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-29-87		23c. NAME OF CEMETERY OR CREMATORY Morning Side Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE DuBois, Clearfield, Pennsylvania	
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service				ADDRESS Upperco, MD.		25a. DATE REC'D. BY REGISTRAR Julia Davidson	
				25b. REGISTRAR'S SIGNATURE Julia Davidson			

JUL 30 1987

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

061352 JUL 30 81



061965 AUG 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20029
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TAFT H. REDD			2a. DATE OF DEATH MONTH DAY YEAR JULY 31, 1987			2b. HOUR P 6:08M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YR 3 20 11		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH		15. MOTHER'S MAIDEN NAME MIDDLE LAST MATTIE		13e. STREET ADDRESS / ZIP CODE 1028 N. CASTLE STREET 21205			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 218-07-4059		17. INFORMANT HELEN REDD 1028 N. CASTLE STREET			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebrovascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute renal failure</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5min</u> <u>2 weeks</u> <u>2 weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>dry gangrene, Gout, Hypertension, metabolic Acidosis, Anemia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>16 JULY 1987</u> to <u>31 JULY 1987</u> , that (we) lost saw the deceased alive on <u>31 JULY 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <u>B. YOKEL</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>7/31/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENJAMIN YOKEL		22e. ADDRESS JOHNS HOPKINS HOSPITAL		22f. CITY OR TOWN BALTO. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/7/87		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS, MD	
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.				ADDRESS 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR AUG 06 1987	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other potentially event, the medical examiner must be notified at once.

BP

[illegible]

060983

JUL 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 200 30

REG. NO.

8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WESLEY REED			2a. DATE OF DEATH MONTH DAY YEAR 7 23 87		2b. HOUR M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1 07 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO. 222-03-7711		17. INFORMANT ADDRESS BALTIMORE, MD. CARRIE REED 1909 DUKELAND STREET 21216	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LCVA OLD & RECENT, REPEATED</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SEIZURE DISORDER, CRF, LL PNEUMONIA S/P.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> 19 <u>86</u> , to <u>7/23</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/23</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A. Enrique</u>				22c. DATE SIGNED 7/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. ENRIQUE, MD				22e. ADDRESS 2435 W BELVEDERE 21245	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/29/1987		23c. NAME OF CEMETERY OR CREMATORY ARBUS MEM. PK.	
23d. LOCATION CITY OR TOWN BALTIMORE, MD.		23e. COUNTY BALTIMORE, MD.			
24. FUNERAL HOME, INC. NAME 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216				25a. DATE REC'D. BY REGISTRAR JUL 28 1987	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				25c. ADDRESS	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of date.

BP

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RECEIVED
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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

REG. NO.

87 20031

2. DECEASED NAME
(LAST OR PRINT)

FIRST MIDDLE LAST
Baby Courtney Girl (Courtney) Reese

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
7-29-87 8:25 A.M.

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
7-27-87

6. AGE (IN YEARS LAST BIRTHDAY)

--- YRS

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore, City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

University of Maryland Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. CITY OR TOWN

Frederick

13c. COUNTRY

Ladysburg

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

12503 Woodsboro Pike/ 21759

14. FATHER'S NAME

FIRST MIDDLE LAST
Michael Reese

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Shawn Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN) No.

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Benson M. Silverman, M.D.U. of Md. Hosp.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) Hyaline Membrane Disease/Pulmonary Interstitial Emphysema

DUE TO, OR AS A CONSEQUENCE OF

(c) Severe Prematurity

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Gram Negative Sepsis////Left Lung Mass

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 7-29-87 to 7-29-87, that (I) (we) lost saw the deceased alive on 7-29-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE

Benson M. Silverman

DEGREE

M.D.

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

7-29-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Benson M. Silverman, M.D.

22e. ADDRESS

Univ. Of Md. Hosp. Div. of Neonatology

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

8/3/87

23c. NAME OF CEMETERY OR CREMATORY

Haugh's Cemetery

23d. LOCATION CITY OR TOWN

Ladysburg Frederick

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

NAME

D. D. Hartzler

ADDRESS

Union Bridge, MD

25a. DATE REC'D. BY REGISTRAR

AUG 06 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

1000 23

08554 AUG 11 85

1000 23

TO HOSPITAL OR ATTENDING PHYSICIAN: The lower portion of this death certificate is to be filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been received by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of other death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.)

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR		87 REG. NO. 20032	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lois G. Reighard		2a. DATE OF DEATH MONTH DAY YEAR 07 06 87 2b. HOUR 7:15 pm	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 13, 1915	
6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. HOURS MIN.
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	9b. CITIZEN OF WHAT COUNTRY? USA	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Own Home	13a. STREET ADDRESS / ZIP CODE 113 Kinship Road Apt 1-A 21222		
13b. STATE Maryland	13c. COUNTY Baltimore	13d. CITY OR TOWN Dundalk	13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph P. Miller	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha E. Gouchnour		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-24-1919	17. INFORMANT ADDRESS Elmer R. Reighard Same as 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multisystem Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Metastatic pancreatic carcinoma.</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 22nd</u> , 19 <u>87</u> , to <u>July 6th</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>July 6th</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.			
22b. SIGNATURE <u>Kurt Campbell</u>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/6/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kurt Campbell</u>	22e. ADDRESS <u>FSK Medical Center, Easdown Ave., Balto., MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-9-87	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gdns.	23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Maryland
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222	25a. DATE REC'D. BY REGISTRAR JUL 13 1987	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the bottom portion (pages 1 and 2) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 20033	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Joseph Reilly, Jr.				2a. DATE OF DEATH MONTH YEAR HOUR July 8, 1987 2 0 3	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81	7b. HOUR 3
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7311 Harford Road 21234		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Area Service Manager Automobile		
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7311 Harford Road 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Reilly		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Gring			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-05-0688	17. INFORMANT ADDRESS Mrs. Genevieve Reilly same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Diabetes mellitus, Type I, with atherosclerotic cerebral impairment					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 15, 1982 to July 8, 1987 , that (I) lost lost saw the deceased alive on April 25, 1987 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) lost (did not) view the body after death.					
22b. SIGNATURE W B Daniels Jr		DEGREE MD		22c. DATE SIGNED 7/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Worth B. Daniels, Jr. M.D.		22e. ADDRESS 11 E. Chase Street Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 07/11/1987	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 13 1987			

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with the following results:

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17. *Journal of the American Medical Association*, 271:1233-1234 (1994).

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CATHERINE Margaret REINHART				7/9/87		00:00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Female	CAU, white	11 20 10		76 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	USA			BALTO. CITY MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Francis Scott Key Medical Center		Retired - Raleighs Seamstress		Seamstress		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
Maryland	Baltimore	Baltimore		503 S. 45th St. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Joseph Lang		Anna Fisher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		212-28-9346		Kenneth J. Reinhart same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>SEPTIC SHOCK</u>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SEVERE DIARRHEA FOR 3 WEEKS</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/8/87</u> 19 <u>87</u> to <u>7/9</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/9</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>J. A. C. Lima</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/9/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>José A C LIMA</u>				22e. ADDRESS <u>FRANCIS SCOTT KEY MEDICAL CENTER</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		7-13-87		Oak Lawn		Baltimore - Maryland	
24. FUNERAL DIRECTOR NAME <u>Duda-Ruck Funeral Home of Dundalk</u>				25a. DATE REC'D BY REGISTRAR <u>JUL 10 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Randall</u>	
7922 Wise Ave. Dundalk, MD 21222							

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

MONTH	DAY	YEAR	HOUR
7/	27/	1987	
MONTH	DAY	YEAR	HOUR
7/	29/	1987	4:30 P

1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST
	Wilhelm	Joseph	Reinich Reinsch

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.	
Male	White	MONTH DAY YEAR 8 29 50	(LAST BIRTHDAY) 36 YRS.	MONTHS	DAYS	HOURS	MIN.

2c. DATE PRONOUNCED DEAD	MONTH 7/	DAY 29/	YEAR 1987	2d. HOUR 4:30 P
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7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City,
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10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 514 Cathedral St.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY Restaurant
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13a. STATE **MD.** 13b. COUNTY **Baltimore** 13c. CITY OR TOWN **Baltimore** 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS **514 Cathedral Street 21201**

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST	FIRST MIDDLE LAST
Frank J. Reinsch	Mildred B. Ritmiller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam	17. INFORMANT ADDRESS Frank J. Reinsch 731 S. Lakewood Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) _____	Alcoholism	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>	(b) _____	
	DUE TO, OR AS A CONSEQUENCE OF	
	(c) _____	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19c. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
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72a. I certify that I took charge of the remains described above and that the **HEAD ONLY** Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE [Signature] TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 7/30/87

EXAMINER'S NAME Dennis F. Smyth, M.D. ADDRESS 111 Penn St.
(TYPE OR PRINT)

23a. BURIAL CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	7-31-87	Maryland Veterans	Garrison, Balto. Co., Md.		

74. FUNERAL DIRECTOR NAME ADDRESS Charles S. Zeiler & Son Inc. 901 S. Conkling	75a. DATE REC'D. BY REGISTRAR AUG 3 1987	75b. REGISTRAR'S SIGNATURE Anita Twidson-Pandolfi
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

NOTES TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, IN LINE 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. COMPLETE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. **NOTES TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL—TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) Frank Edward Reuter					2a. DATE OF DEATH MONTH 7 DAY 9 YEAR 87 HOUR 5:30 A.M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 1 DAY 24 YEAR 13		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		
13a. STATE Md.					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST John MIDDLE LAST Reuter					15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE LAST Kafer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-09-0351		17. INFORMANT ADDRESS Inene J. Reuter 502 Tolna Street 21224						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) severe COPD DUE TO, OR AS A CONSEQUENCE OF (c) 										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): seizure disorder, status epilepticus										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 5/3/87 to 7/9 , 19 87 , that (I) (we) lost saw the deceased alive on 7/8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE W. Mat MD					DEGREE MD			22c. DATE SIGNED 7/9/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wendy Mat MD					22e. ADDRESS Francis Scott Key Hosp.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-13-87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Eastwood, Baltimore Co., Md.				
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc. ADDRESS 6224 Eastern Ave.					25a. DATE REC'D. BY REGISTRAR JUL 10 1987		25b. REGISTRAR'S SIGNATURE Gina Anderson			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20031

1. DECEASED NAME (TYPE OR PRINT) Kevin Reynolds										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7/ 26/ 19 87		2b. HOUR 3:24 a			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 18 59		6. AGE (IN YEARS) MONTH DAY YEAR 27		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7/ 26/ 19 87		2d. HOUR 3:24 a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD			
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2600 Blk. Edmondson Ave.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tree Surgeon				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3516 Park Heights Ave. 21215					
14. FATHER'S NAME FIRST MIDDLE LAST William Reynolds Jr.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gloria Freeman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-88-6633				17. INFORMANT William Reynolds Jr.				ADDRESS 3516 Park Heights Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wounds (2) of Head (unspecified) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 10															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:05 PM 7/26/ 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) alley in rear				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2600 Blk. Edmondson Ave., Balto. City, Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Margaret Meyhell				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 7/26/87			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/30/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. MD					
24. FUNERAL DIRECTOR William C. Brown				ADDRESS 1206 W. North Ave.				25a. DATE REC'D. BY REGISTRAR JUL 29 1987				25b. REGISTRAR'S SIGNATURE Julia Tindon-Randall			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20038

1. DECEASED NAME (TYPE OR PRINT) GUY D. RICH			2a. DATE OF DEATH MONTH DAY YEAR JULY 27, 1987		2b. HOUR 10:50A M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 12 31 22		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 214 N. WASHINGTON 21231
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE RICH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HATTIE HINES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 213-16-6993	17. INFORMANT ADDRESS PAULA HATTEN 214 N. WASHINGTON ST.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>adenocarcinoma of lung</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>3 wks</u> <u>4 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>emphysema</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from <u>7/12</u> 19 <u>87</u> , to <u>7/27</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>7/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John B. Williams</u>		DEGREE <u>MD/PhD</u>		22c. DATE SIGNED <u>7/27/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John B. Williams</u>		22e. ADDRESS <u>600 N Wolfe Balt. MD 21205</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>8/3/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GARRISON FOREST</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>OWINGS MILLS MD</u>
24. FUNERAL DIRECTOR NAME <u>WM. C. MARCH F/H, INC.</u>			25a. DATE REC'D. BY REGISTRAR <u>JUL 31 1987</u>		
			25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

BP

00148 AUG-40

57 60 141

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) Edgar A. Richards					2a. DATE OF DEATH MONTH DAY YEAR 07 04 87		2b. HOUR 5:50 A.M.		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 06 27 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4324 Falls Road 21211	
14. FATHER'S NAME FIRST MIDDLE LAST John C. Richards				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Tulin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Melvin Bernstein 1114 W. 36th Street 21211					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO, OR AS A CONSEQUENCE OF (c) Probable Pneumonia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS DAYS Week	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>06/27</u> , 19 <u>87</u> , to <u>4 July</u> , 19 <u>87</u> , that (II) <u>we</u> lost saw the deceased alive on <u>4 July</u> , 19 <u>87</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above (I) <u>we</u> (did) (did not) view the body after death.									
22b. SIGNATURE Paul A. Tarantino				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 4 July 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A. TARANTINO				22e. ADDRESS MERCY HOSPITAL BALT MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/8/87		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211				25a. DATE REC'D BY REGISTRAR JUL 06 1987		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall			

061110 JUL 29 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20040

REG. NO.

1- STATE
REGISTRAR2- DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ALLEN

RICHARDSON

2a. DATE KNOWN ☒ MONTH DAY YEAR 2b. HOUR
OF DEATH ESTI- ☐ 7-25-87¹⁹ M

3- SEX

4- RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2d. HOUR
7-25-87¹⁹ 5:20P7a. BIRTHPLACE (STATE OR
CITY OR TOWN)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1325 Wilcox Street12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
Truck Driver12b. KIND OF BUSINESS
OR INDUSTRY

13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

13e. STREET ADDRESS

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO16b. SOCIAL SECURITY NO.
217-16-6539

17. INFORMANT

ADDRESS

Vicki Jones 4912 ALHAMBRA AVE 21212

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hypertensive cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

TITLE (SPECIFY)

Deputy Chief

MEDICAL EXAMINER

DATE 7-28-87
SIGNEDEXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATOR

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR
(NAME)

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Redd Funeral Home 529 York JUL 28 1987

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED FOR BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS (201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20041

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Bessie Carmelita Richardson

2a. DATE OF DEATH

MONTH

DAY

YEAR

7 25 87

2b. HOUR

M

3. SEX

Female

4. RACE

Black

5. DATE OF BIRTH

MONTH

DAY

YEAR

1 25 12

6. AGE (IN YEARS (LAST BIRTHDAY))

IF UNDER 1 YEAR

IF UNDER 24 HRS.

75

YRS.

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Md.

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
206 N. Monastery Ave.

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

13c. CITY OR TOWN

Balto.

13d. INSIDE CITY LIMITS?

YES ☒NO ☐

13e. STREET ADDRESS / ZIP CODE

206 N. Monastery Ave. 21229

14. FATHER'S NAME

William

MIDDLE

Richardson

15. MOTHER'S MAIDEN NAME

Sarah

MIDDLE

Reid

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)
No

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)
214-01-2445

17. INFORMANT

ADDRESS

Rosetta Collins 206 N. Monastery Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Chronic Atrial fibrillation

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Hypertension, Cerebral Palsy

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 6/1/1987 to 6/1/1987, that (I) saw the deceased alive on 6/1/1987, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Shanti Ramesh

DEGREE

Resident Physician

ATTENDING
PHYSICIAN ☐MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

7/27/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SHANTI RAMESH

22e. ADDRESS

St. Agnes Hospital

900 Caton Avenue, Baltimore, MD 21229

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

7/28/87

23c. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cemetery

23d. LOCATION

Baltimore

COUNTY

STATE

Md.

24. FUNERAL DIRECTOR

Chatman-Harris FH 1701 McCulloh Street

25a. DATE REC'D. BY REGISTRAR

30 1987

REGISTRAR'S SIGNATURE

001308 JUL 08 1964

061270 JUL 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 REG. NO. 20042
2a. DATE OF DEATH MONTH DAY YEAR 7 24 87 13 M

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Merlyn Jean Richardson		2a. DATE OF DEATH MONTH DAY YEAR 7 24 87 13 M	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 16 34	6. AGE (IN YEARS LAST BIRTHDAY) 52 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Fremont, N.C.	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto., City MD.
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1638 N. Broadway		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Jessie Richardson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Battle	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 219-32-7848	17. INFORMANT ADDRESS Deborah L. Fogg 1607 Laurelton Ave.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DIABETES MELLITUS</u> (c) <u>HYPERTENSION</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 1 YEAR 1 YEAR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>PANCREATITIS</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>DEC 3, 1986</u> to <u>JULY 19, 1987</u> , that (I) (we) lost saw the deceased alive on <u>7-8-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Carlton C. Greene MD</u> DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CARLTON C. GREENE</u>		22e. ADDRESS <u>220 W. COLDSRING LANE.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>7/29/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto. Md.</u>
24. FUNERAL DIRECTOR NAME <u>William C. Brown</u> ADDRESS <u>1206 W. North Ave.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 29 1987</u>	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

061510 JUL 30 81

JUL 29 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 20043

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
JAMES RIDER				JULY 7, 1987		5:15aM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
MALE	CAUC.	2.16.95		92 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD	
GEORGIA	USA			BALTIMORE CITY			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	CHURCH HOSPITAL		RETIRED				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND				BALTIMORE			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE			
SAMUEL RIDER		LOU RIDER		624 S. BRADFORD ST. 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF "YES" GIVE SERVICE NUMBER)		16b. SOCIAL SECURITY NO.		17. INFORMANT'S NAME ADDRESS			
YES WW-I		218014419		LINDA CAMPBELL 624 S. BRADFORD ST. 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DECUBITUS ULCER							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JUNE 9, 19 87, to JULY 7, 19 87, that (I) (we) lost saw the deceased alive on JULY 7, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
V.M. ABHYANKAR		M.D.					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
V.M. ABHYANKAR, M.D.		CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD 21231					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
CREMATION		7-10-87		WESTVIEW Cem.		BALTIMORE MD	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
KACZOROWSKI FUNERAL HOME Fleet St.		JUL 10 1987		Julia Tisdale Rader			

BP

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NEW YORK

060338 JUL 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8720044

2a. DECEASED NAME (TYPE OR PRINT) Robert Walter Rider			2b. DATE OF DEATH MONTH DAY YEAR July 17, 1987		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 28 1926		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	
7a. BIRTHPLACE (COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouse Sup.		12b. KIND OF BUSINESS OR INDUSTRY Budeke Paint
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Doll Rider			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Marie Merryman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 214207970		17. INFORMANT ADDRESS Robin Rider Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>—</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 77</u> , 19 <u>77</u> , to <u>Present</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>7-6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John S. Sin</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>7-17-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>INDEN SIN</u>		22e. ADDRESS <u>2301 St. Annapolis Rd Balto Md 21230</u>			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE July 20 1987	23c. NAME OF CEMETERY OR CREMATORY Meadowridge MEM		23d. LOCATION CITY OR TOWN COUNTY STATE Elridge Howard Md.
24. FUNERAL DIRECTOR NAME McCully Funeral Home		150 E. Fort Ave Balto. Md. 21230		25a. DATE REC'D. BY REGISTRAR JUL 21 1987	
25b. REGISTRAR'S SIGNATURE <u>John S. Sin</u>					

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UNITED STATES OF AMERICA

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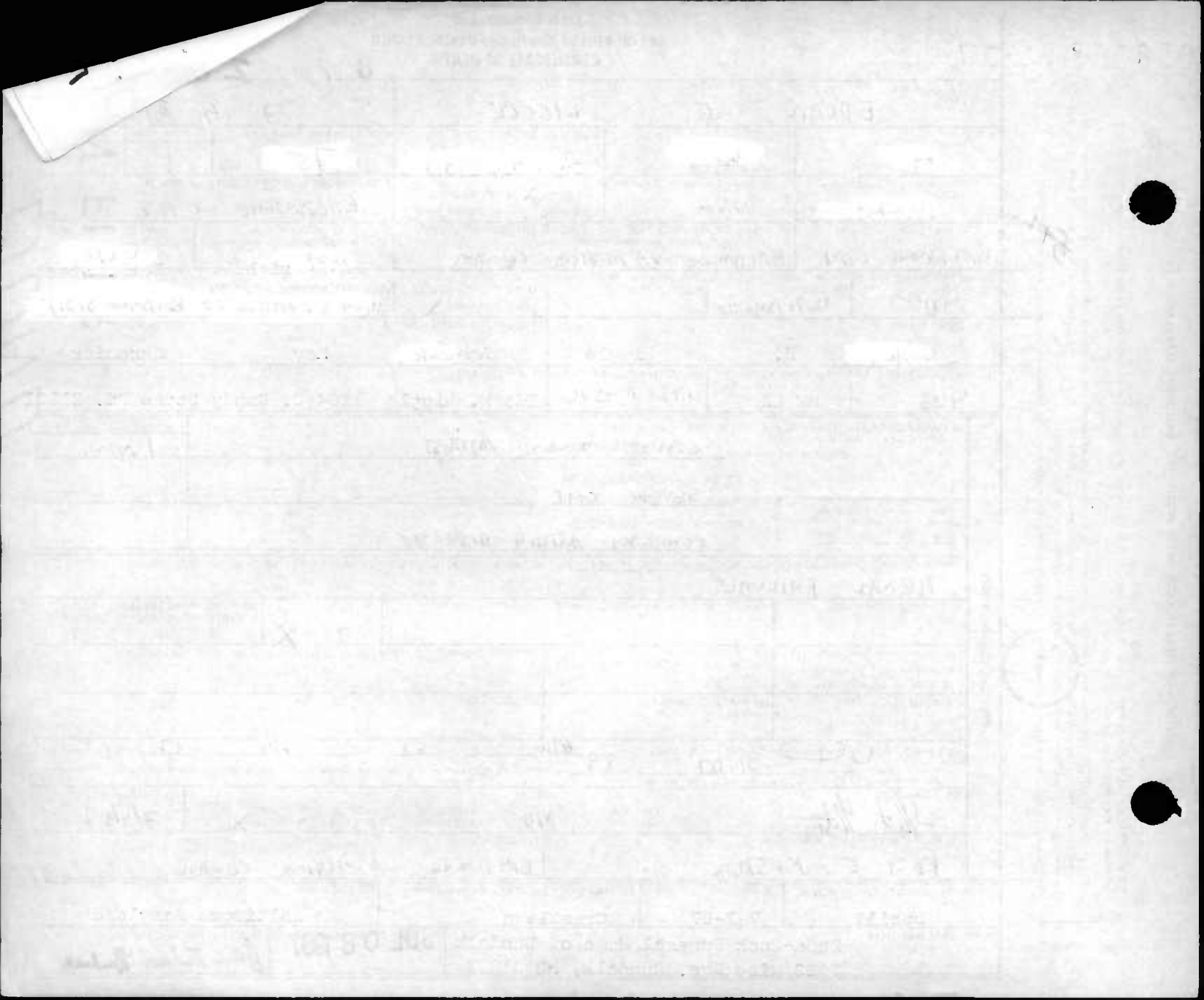
WINTER



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20045

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDGAR E RIGGLE		2a. DATE OF DEATH MONTH DAY YEAR 7 4 87		HOURS MIN. 10 30	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 15, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE VA MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mill Wright		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel
13a. STATE MD	13b. COUNTY BALTIMORE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1104 C. Sandy Stone Road 21221	
14. FATHER'S NAME FIRST MIDDLE LAST Edgar B. Riggle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ameli May Stromier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Ida M. Riggle 1104 C. Sandy Stone Rd. 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEVERE CHF</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONVULSIVE ARTERY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>RENAL FAILURE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (his hospital) attended the deceased from <u>6/16</u> , 19 <u>87</u> , to <u>7/4</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>7/4/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Kent E. Keston</u>		DEGREE MD		22c. DATE SIGNED 7/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENT E. KESTON		22e. ADDRESS BALTIMORE VA MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-7-87	23c. NAME OF CEMETERY OR CREMATORY Crestlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, MD 21222		25a. DATE RECD. BY REGISTRAR JUL 08 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 20046

1. DECEASED NAME (FIRST, MIDDLE, LAST) JUAN RIOS			2a. DATE OF DEATH (MONTH, DAY, YEAR) JULY 29, 1987		2b. HOUR 3:01 A.M.						
3. SEX MALE		4. RACE MEXICAN		5. DATE OF BIRTH (MONTH, DAY, YEAR) 11 4 34		6. AGE (IN YEARS LAST BIRTHDAY) 52		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MEXICO		7b. CITIZEN OF WHAT COUNTRY? MEX.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO TECH.		12b. KIND OF BUSINESS OR INDUSTRY SHERWOOD FORD			
13a. STATE MD			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1253 LINWORTH AVE. 21239		
14. FATHER'S NAME (FIRST, MIDDLE, LAST) MANUEL RIOS			15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST) ALICIA C. CASTELAZO								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 001-34-3804		17. INFORMANT MIRANDA RIOS		ADDRESS 1253 LINWORTH AVE. 2A					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) 6 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/29/87 19____, to 7/29/87 19____, that (I) (we) last saw the deceased alive on 7/29/87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Philip Keiser MD						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip Keiser						22e. ADDRESS 100 N Wolfe St Balto Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 8/3/87		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD				
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.						ADDRESS 1101 E. NORTH AVE.		25. DATE REGD. BY REGISTRAR JUL 31 1987		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 4 and 5 should be detached for use as the burial-transit permit. Then please remove this certificate from the file. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked "I" shows any injury, or other traumatic event, the medical examiner must be notified at once.

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062000 AUG 8 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 REG. NO. 2 0 0 4 1

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST GLADYS		MIDDLE		LAST Roberts		2a. DATE OF DEATH MONTH DAY YEAR		7 31 87		2b. HOUR 114 PM	
3. SEX F		4. RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR		12 31 31		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Balt'o		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4003 Boorman Ave 21215	
14. FATHER'S NAME FIRST MIDDLE LAST Freddie McCaro		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alease Richardson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 227-52-9013		17. INFORMANT Clarence Roberts		ADDRESS 4003 Boorman Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Septic Disseminated Intravascular Coagulation DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Breast Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
27b. SIGNATURE GALARRAGA		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		27c. DATE SIGNED 7/31/87							
27d. PHYSICIAN'S NAME (TYPE OR PRINT) GALARRAGA		27e. ADDRESS Sinai Hospital											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/6/87		23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD							
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue		ADDRESS		25a. DATE REC'D BY REGISTRAR AUG 06 1987		25b. REGISTRAR'S SIGNATURE Julia Bender-Rodriguez							

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20048

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances, O. Roberts		2a. DATE OF DEATH MONTH DAY YEAR 07-09-87		2b. HOUR 10⁵³ AM	
3. SEX Female	4. RACE Col. 2	5. DATE OF BIRTH MONTH DAY YEAR 7-31-1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kellow S.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Med. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS ZIP CODE 3306 Windsor Ave. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Mark Dixon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Harrington		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 162-369915		17. INFORMANT ADDRESS Miss Virginia Roberts 3306 Windsor Ave 21216		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) sepsis, A SUD DUE TO, OR AS A CONSEQUENCE OF (c) Status Post cerebral vascular accident					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Urinary Tract infection; Renal failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 2, 1987 , to July 9, 1987 , that (I) (we) last saw the deceased alive on July 9, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Franklin J. Addison MD				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Franklin J. Addison MD				22e. ADDRESS 924 W. North Ave	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 7/14/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus mem ph Bldg	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md		24. FUNERAL DIRECTOR NAME ADDRESS Angel & Russ 2222 W York Ave			
25a. DATE REC'D. BY REGISTRAR JUL 16 1987		25b. REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial form. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENKIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Frank L. Robertson Sr.			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7-5 1987			2b. HOUR M A 12:50 A		
3. SEX male	4. RACE Cld	5. DATE OF BIRTH MONTH DAY YEAR 7-31-49	6. AGE (IN YEARS) LAST BIRTHDAY 38 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7-5 1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila. Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1653 Shadyside Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec. office		12b. KIND OF BUSINESS OR INDUSTRY Stated 9nd
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1653 Shadyside Rd. 21218		
14. FATHER'S NAME FIRST MIDDLE LAST SILAS Robertson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LEONA Bruce		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				
16b. SOCIAL SECURITY NO. 219-50-5849		17. INFORMANT ADDRESS Mrs. Maxine Robertson 1653 Shadyside Rd. 21218						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY 7-4-87 HOUR A.M. MONTH DAY YEAR approx 10:30PM		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1653 Shadyside Road Baltimore City, MD				
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy Chief			DATE SIGNED 7-5-87			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn Street, Baltimore, MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-11-87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Tpk. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md		
24. FUNERAL DIRECTOR NAME Joseph L. Russ		ADDRESS 2022 W. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 9 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall		

Photo 78

100% COTTON FIBER



MADE IN U.S.A.



July 8 1967

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JUL 24 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 8 7

20050

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELOISE ROBINSON			2a. DATE OF DEATH MONTH DAY YEAR July 18, 1987		2b. HOUR M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 11 19		6. AGE (IN YEARS LAST BIRTHDAY) 68	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1329 N. Milton AVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Lane Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Williams			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 240-09-1396		17. INFORMANT ADDRESS Valoris Robinson 1329 N. Milton Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Metastatic Ovarian Cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mo
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (b).					
DUE TO, OR AS A CONSEQUENCE OF (c).					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 7b, PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a. I certify that in (this hospital) I attended the deceased from July 1 , 19 87 , to July 18 , 19 87 , that (I) (we) last saw the deceased alive on July 13 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.)					
22b. SIGNATURE Colin M. Lellan				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. LELLAN				22e. ADDRESS Johas Hopkins Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/24/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D BY REGISTRAR (IN RECORD YEARS SIGNATURE) JUL 23 1987 Julia Dendron-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

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UNITED STATES DEPARTMENT OF AGRICULTURE
NATIONAL AGRICULTURAL LIBRARY
WASHINGTON, D.C. 20503

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AUG - 4 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH20051
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
HENRY						ROBINSON		ESTIMATED MATED		7		27		1987		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	BLACK	7. 5 20		67 YRS.						7		27		1987		8:50 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
S.C.		U.S.A.		WIDOWED		DIVORCED		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		753 Ramsay St.		RETIRED		N/A											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		753 Ramsay Street 21230									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
WILLIE		MISSOURI															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS													
NO		249-12-2102		SARAH MACK 5604 WOODMONT AVE. APT. A													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?			
														YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
		M.D. Deputy Chief		7-28-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Ann M. Dixon, M.D.		111 Penn St., Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
BURIAL		8/1/87		KING MEMORIAL PK.		RANDALLSTOWN,		MD									
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
WM. C. MARCH F/H, INC.		JUL 31 1987		John Dixon-Randall													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THIS CERTIFICATE IS VALID FOR 14 DAYS. IF THE DEATH IS NOT REPORTED WITHIN 14 DAYS, THE CERTIFICATE WILL BE VOID. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 4 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. THIS CERTIFICATE SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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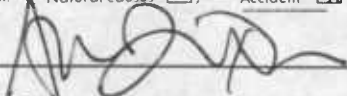
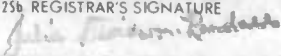


060662 JUL 24 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20052

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARION ROBINSON			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 7 21 19 87			2b. HOUR M 10:23 A		
3. SEX M	4. RACE C	5. DATE OF BIRTH MONTH DAY YEAR 9 2 14 72	6. AGE (IN YEARS) (LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 21 19 87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ORANGEBURG			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) bathtub - 918 N. Monroe St.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NOT EMPLOYED			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE MD		
13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 918 N. Monroe St			14. FATHER'S NAME FIRST MIDDLE LAST Elmer Robinson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 251-26-6776			17. INFORMANT ADDRESS BARBARA ROBINSON		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9104 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease complicated by drowning Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7-21-19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject drowned in bathtub.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) bathtub		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 918 N. Monroe St., Balto. MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 			TITLE (SPECIFY) Deputy			DATE SIGNED 7-21-87		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/27/87		23c. NAME OF CEMETERY OR CREMATORY MD Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Greenbelt MD MD	
24. FUNERAL DIRECTOR NAME ADDRESS Marlene Adams 626 49.1000 44			25a. DATE REC'D. BY REGISTRAR JUL 23 1987			25b. REGISTRAR'S SIGNATURE 		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. RETAIN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 200053

FOR
1- STATE
REGISTRAR

2a. DEATH KNOWN ☒ MONTH DAY YEAR 2b. HOUR
OF ESTIMATED ☐ 7-18-87 M

FIRST MIDDLE LAST
PAUL P. ROBINSON

3. SEX
M

4. RACE
B

5. DATE OF BIRTH
MONTH DAY YEAR
12 2 87

6. AGE (IN YEARS)
(LAST BIRTHDAY)
21 YRS.

IF UNDER 1 YR.
MONTHS DAYS

IF UNDER 24 HRS.
HOURS MIN.

2c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR
7-18-87

2d. HOUR
12:55

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)
MD

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City

MD

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Mercy Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)
UNEMPLOYED

12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD

13b. COUNTY

13c. CITY OR TOWN
BALTIMORE

13d. INSIDE CITY LIMITS?
YES ☒ NO ☐

13e. STREET ADDRESS
416 E. BIDDLE ST. 21202

14. FATHER'S NAME
FIRST MIDDLE LAST
SAMUEL P. ROBINSON

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
REGINA WALKER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.
214-74-8083

17. INFORMANT
ADDRESS
REGINA WALKER 1201 WOODINGTON RD. 21229

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Narcotic intoxication complicated by seizure

~~XXXXXXXXXXXXXXXXXXXX~~

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) and renal failure

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 7-22-87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
subject used drugs

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACILITY, FARM, ETC.)
unknown

21f. LOCATION
STREET
unknown

CITY OR TOWN COUNTY STATE
Baltimore, Maryland

22a. I certify that I took charge of the remains described above, held an autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion
death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL
SIGNATURE

TITLE (SPECIFY)
M.D. Chief

MEDICAL EXAMINER

DATE SIGNED 7-19-87

EXAMINER'S NAME
(TYPE OR PRINT)

John E. Smialek, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL

23b. DATE
7/25/87

23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE CEMETERY

23d. LOCATION
CITY OR TOWN
BALTIMORE

COUNTY

STATE
MD

24. FUNERAL DIRECTOR
NAME

ADDRESS

WM. C. MARCH F/H

1101 E. NORTH AVE.

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

24 1987

Julia Gordon-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 3. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20054

1. DECEASED NAME (TYPE OR PRINT) Raphael Rayfield Robinson		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7/ 8/ 19 87		2b. HOUR 8:32 P M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 4 6 31	6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.	7. IF UNDER 1 YR. MONTHS DAYS 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2259 Madison Ave.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Spriggs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 218-26-6171		17. INFORMANT ADDRESS Louise Spriggs 2259 Madison Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant		DATE SIGNED 7/9/87
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-14-87	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest V.A.	23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mill Md	
24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Home 1101 E. North Ave.		25a. DATE REC'D BY REGISTRAR JUL 13 1987	25b. REGISTRAR'S SIGNATURE <i>John F. Rudee</i>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20055

1. DECEASED NAME (TYPE OR PRINT) BABY GIRL				2a. DATE OF DEATH JULY 9, 1987				2b. HOUR 6:10P M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR June 19, 1987		6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS 0 MONTHS 20 DAYS		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3436 Ripple Road 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Robert T. Robinson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carol Harrison		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Robert T. Robinson 3436 Ripple Rd. 21207	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-pulmonary arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 min	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) severe hyaline membrane disease								20 days	
DUE TO, OR AS A CONSEQUENCE OF (c) prematurity								20 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Tracheo-esophageal fistula									
19a. DATE OF OPERATION 6/30/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED T. E. F. (tracheo esophageal fistula)				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 6/20 19 87 to 6/30/87 19 87 , that (I) (we) last saw the deceased alive on 7/9 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Kevin B. Johnson				DEGREE M.D.				22c. DATE SIGNED 7/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin B. Johnson MD				22e. ADDRESS The Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 13, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY Brooklyn, A.A. County, Md.			
24. FUNERAL DIRECTOR NAME Marshall W. Jones, Jr. FH 4101 Edmondson Ave				25a. DATE REC'D. BY REGISTRAR JUL 13 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Signs

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mary Elizabeth Rodemeyer		2a. DATE OF DEATH MONTH DAY YEAR 7-11-87		2b. HOUR 1:17 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12-8-95		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS
7a. BIRTHPLACE COUNTRY (STATE OR FOREIGN) Md.	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Balto. Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Hecht Co.	
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Francis E. Crosbie		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Aul		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 213-09-4749		17. INFORMANT ADDRESS Mr. Frank W. Rodemeyer Same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer DUE TO, OR AS A CONSEQUENCE OF (b) metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Serious Arterio.				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 6-21-87 to 7-4-87 , that (I) (we) lost saw the deceased alive on 7-10-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Dr. [Signature]		DEGREE MD		22c. DATE SIGNED 7-11-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AJIDIA C. SIDHE		22e. ADDRESS 5000 Adl. North. Pike 21228		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 15, 1987	23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 15 1987		25b. REGISTRAR'S SIGNATURE Julia [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Very Respectfully,
Robert H. Kennedy

With

A.

W.

Robert H. Kennedy

600 Lexington Ave. 10017

x

Salisbury

and

Robert

Grassie

2.

Francis

215-05-4745 R. Frank A. Kennedy, Jr.

no



Woodlawn Baltimore Md.

July 12, 1967 Woodlawn

Initial

Robert H. Kennedy, Jr. Baltimore, Maryland

JUL 12 1967

061473 JUL 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

20057
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS J. ROHE JR.			2a. DATE OF DEATH MONTH DAY YEAR JULY 27, 1987			2b. HOUR 7 ¹⁷ M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 23, 1910		6. AGE (IN YEARS (LAST BIRTHDAY)) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			12b. KIND OF BUSINESS OR INDUSTRY MILLWRIGHT	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 305 NOTTINGHAM ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MILLWRIGHT		12b. KIND OF BUSINESS OR INDUSTRY STEEL		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 305 NOTTINGHAM ROAD 21229		
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS J. ROHE SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELIZABETH STROMBERG		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-01-6401		17. INFORMANT ADDRESS 303 COLUMBIA LANE STEVENSVILLE, MD. 21666		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and) not view the body after death.										
22b. SIGNATURE _____ DEGREE				22c. DATE SIGNED 7/30/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leroy M. & Russell C. Witzke				22e. ADDRESS 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/30/87		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE				25a. DATE REC'D. BY REGISTRAR JUL 31 1987		25b. REGISTRAR'S SIGNATURE _____ FUNDAMENTAL HOMES P.A.				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

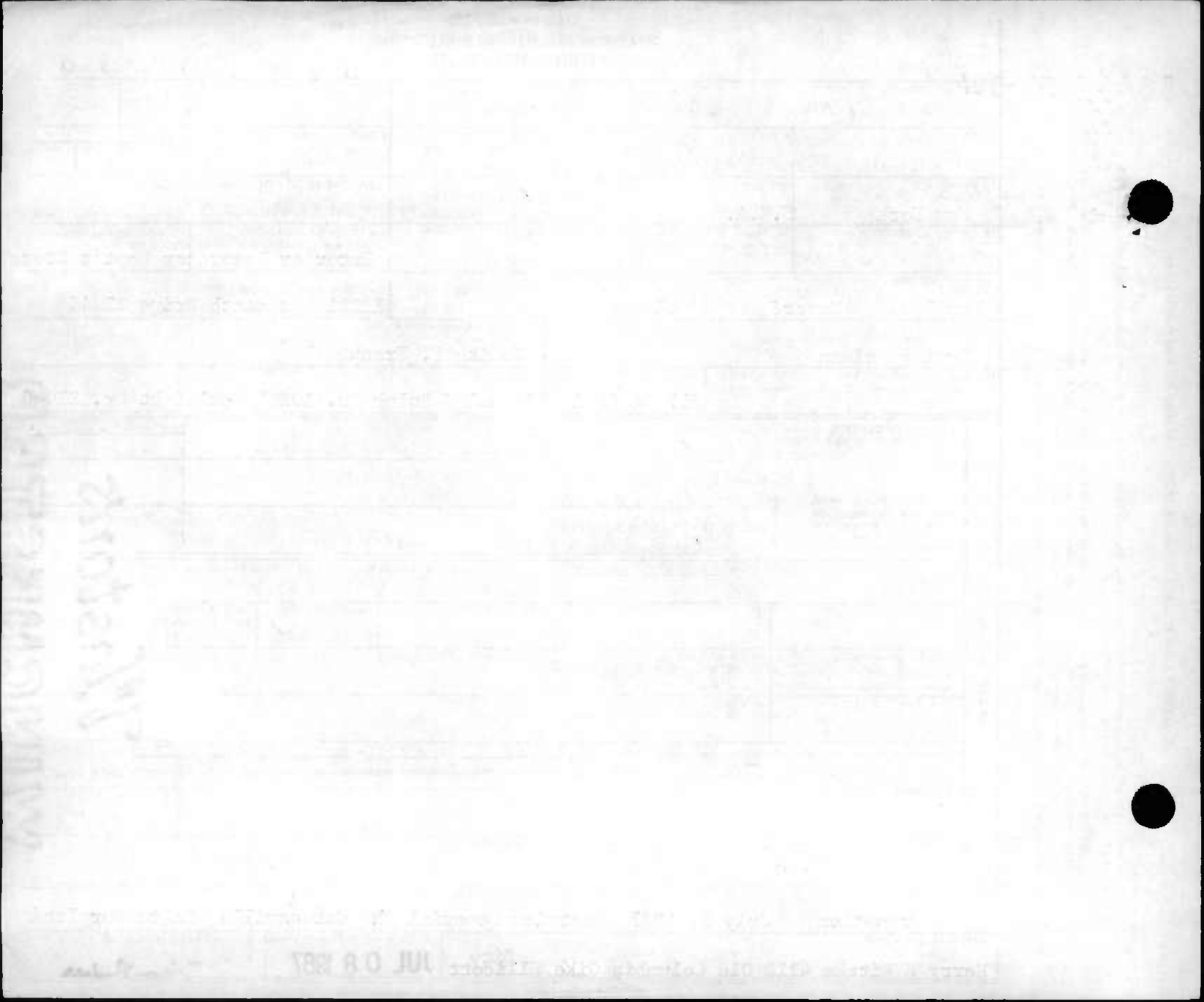
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20058

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VAN ELLIN ROLPH			2a. DATE OF DEATH MONTH DAY YEAR 07 02 87		2b. HOUR 3:40 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 19 31		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.		
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Columbia		
14. FATHER'S NAME FIRST MIDDLE LAST Irving Weiman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Judith F. Frank		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Interior Decorator		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 44 0781		17. INFORMANT ADDRESS Samuel J Rolph Jr. 10221 Wesleight Dr. 21046		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchiectasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Immobile cilia syndrome</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1/87</u> 19 <u>87</u> to <u>7/2</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Latha K Pillai</u>				22c. DATE SIGNED <u>7/2/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PILLAI, LATHA</u>				22e. ADDRESS <u>St Agnes Hospital</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE July 3, 1987		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Pk		
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Maryland		23e. DATE REC'D. BY REGISTRAR JUL 08 1987				
24. FUNERAL DIRECTOR NAME Harry H Witzke		ADDRESS 4112 Old Columbia Rd		25a. REGISTRAR'S SIGNATURE <u>Harold P. ...</u>		



JUL 8 1987

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FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 REG. NO. 20059
DATE OF DEATH 7 31 87 8:40 PM

1. DECEASED NAME (TYPE OR PRINT) Thelma Elizabeth Romeo		3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 9 DAY 15 YEAR 14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE ADDRESS) University Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker		13a. STATE MD		13b. COUNTY Baltimore	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 224 Detroit Ave / 21222		14. FATHER'S NAME FIRST James MIDDLE Homer LAST Wamer	
14. FATHER'S NAME FIRST James MIDDLE Homer LAST Wamer		15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE Kathleen LAST Wright		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-12-5873		17. INFORMANT Sandra K. Romeo		17. ADDRESS 224 Detroit Avenue / 21222	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs	
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction			
DUE TO, OR AS A CONSEQUENCE OF (c) Ventricular Septal Defect			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 7/31/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cardiogenic Shock, Ventricular Defect		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/31 , 19 87 , to 7/31 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE [Signature]		DEGREE MD		22c. DATE SIGNED 7/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fischgrund		22e. ADDRESS U. of Maryland Hospital					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE August 3, 1987		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc.		ADDRESS Dundalk, Md. 21222		25a. DATE REC'D. BY REGISTRAR AUG 04 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the required papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas W. Rorie					2a. DATE OF DEATH MONTH DAY YEAR 7/ 12/ 87			2b. HOUR M	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 10 28 26		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2608 Mura Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maint-Parks		12b. KIND OF BUSINESS OR INDUSTRY Balto. City	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN Md. Balto.					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST Unk					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Ward				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 249 32 1177		17. INFORMANT ADDRESS Evelyn Rorie 2608 Mura St. 21213					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic cerebrovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Multiple Injuries</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>R. L. Robinson</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-14-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. L. Robinson				22e. ADDRESS 15 Calvert Street Suite 300 Balto. MD 21202					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 7/17/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS James A. Morton & Sons 1701 Laurens St.				25a. DATE REC'D. BY REGISTRAR JUL 15 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20061
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>SAMUEL T. ROSS</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7-28-87</i>		2b. HOUR <i>7 P.M.</i>	
3. SEX <i>MALE</i>		4. RACE <i>COLORED</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>SEPT. 3 1912</i>		
6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Mt. CO. Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY MD</i>		10. CITY OR TOWN OF DEATH <i>BALTO. CITY</i>				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>740 Poplar Grove St BALTO. Md</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>DOCK WORKER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>TRUCKING</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i>		13b. COUNTY <i>BALTO. Md.</i>		13c. CITY OR TOWN <i>BALTO. Md.</i>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>740 Poplar Grove St</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>ALFRED ROSS</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ALBERTA GROSS</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>114-18-63084</i>		17. INFORMANT <i>SYLVIA ROSS 2854 W. LANVALE ST.</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure with dysrhythmias 7 years</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease several years</i> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERWAYING <input type="checkbox"/> (OR CONTRIBUTING TO CAUSE OF DEATH (IF SUBMITTER NOTIFY MEDICAL EXAMINER))		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 (OR PART 2))			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/28 1987</i> to <i>7/28 1987</i> that (I) (we) last saw the deceased alive on above, (I) (we) (did not) view the body after death.							
23a. SIGNATURE <i>D. W. Stewart, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23b. DATE SIGNED <i>7/29/87</i>	
24a. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D. W. STEWART</i>		24b. ADDRESS <i>2300 GARRISON BLVD.</i>					

25a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		25b. DATE <i>8-1-87</i>		25c. NAME OF CEMETERY OR CREMATORY <i>MOSES CEMETERY</i>		25d. LOCATION CITY OR TOWN COUNTY STATE <i>LOTHAN A.A. CO. Md.</i>			
26. FUNERAL DIRECTOR NAME ADDRESS <i>Isaiah W. Hayes 3112 Reisterstown Rd. 21215</i>				27a. DATE RECEIVED BY REGISTRAR <i>JUL 30 1987</i>				27b. REGISTRAR'S SIGNATURE <i>Julia Henderson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALAN LEONARD ROSSI					REG. NO. 20062				
2. DATE OF DEATH MONTH DAY YEAR 7 11 87					3. HOUR 4:10p _M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 17 50		6. AGE (IN YEARS LAST BIRTHDAY) 37		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Uniontown Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Schoorman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3805 Marriottsville Rd. 21133	
14. FATHER'S NAME FIRST MIDDLE LAST Vero Edward Rossi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Purnell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 213-60-4410		17. INFORMANT ADDRESS Mr. Vero E. Rossi Randallstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>infarct in the anterior wall of the heart</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertension and atherosclerosis of the heart</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7/11 7/6 - 7/11 "									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Hodgkins Disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:00 P.M. 7 11 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his hospital) attended the deceased from 6/3/87 to 7/11/87, that (I) (we) last saw the deceased alive on 7/11/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>T J Camper</i>				DEGREE MD				22c. DATE SIGNED 7/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T J Camper				22e. ADDRESS 900 S. CATON AVENUE BALTO. MD. 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE July 12, 87		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead, Md.			
24. FUNERAL DIRECTOR Eline Funeral Home Reisterstown, Md. 21136				25a. DATE REC'D. BY REGISTRAR JUL 13 1987		25b. REGISTRAR'S SIGNATURE			

060337 JUL 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20063

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
		JOHN DENIS ROTH				07-18-87		18 87		7:23A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		MONTH DAY YEAR 12 18 34		52 YRS					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		St. Agnes Hospital		Ret / U.S. Navy		LT.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		21208	
MD.		BALTIMORE		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4523 Old Court Rd.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
JOHN F. ROTH		Helen L. GREINUS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, AND OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APT 28 1 MONTROSE MANOR		CATONSVILLE, MD.		21228	
Yes		? - 1957		HELEN L. ROTH							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		sepsis				cryptococcal meningitis		Acquired Immunodeficiency Syndrome			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
N/A		N/A		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR P.M. 19		N/A							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				N/A							
22a. I certify that (I) (this hospital) attended the deceased from 7-2 7-18 1987, to 7-18 1987 that (I) (we) lost saw the deceased alive on 7-18 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
T. H. H.						7-18-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
T. H. H.		ST. AGNES HOSPITAL, BALTIMORE, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
BURIAL		7/21/87		ST. CHARLES		PIKESVILLE				MARYLAND	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228		JUL 21 1987		Julia Gordon-Randall							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20064

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank A. ROTT			2a. DATE OF DEATH MONTH DAY YEAR 7.25.87		2b. HOUR 9 PM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2-14-1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 yrs.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipfitter		12b. KIND OF BUSINESS OR INDUSTRY Union		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Rott			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hofling			13e. STREET ADDRESS / ZIP CODE 124 S. Bouldin Street 21224		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-20-5902		17. INFORMANT ADDRESS George Rott 3533 Northway Drive				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Arrhythmia s/p MI, pneumonia 11 wk DUE TO, OR AS A CONSEQUENCE OF (c) s/p MI, Renal failure, COPD yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several wk								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. CA of Colon CA of Bladder COPD Dementia Renal CA								
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/25/87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME-STREET, FACTORY, OFFICE, FARM, ETC.) 7/25/87		21f. LOCATION CITY OR TOWN COUNTY STATE Death				
22. I certify that (I) (this hospital) attended the deceased from 7/25/87 19__ to Death 19__, that (I) (we) last saw the deceased alive on 7/25/87 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE James S. Novick		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/26/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James S. Novick		22e. ADDRESS Union Memorial Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-29-87		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.		
24. FUNERAL DIRECTOR Schmunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213				25a. DATE REC'D. BY REGISTRAR JUL 27 1987		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by date.

BP

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UNITED STATES GOVERNMENT
OFFICE OF THE SECRETARY OF DEFENSE
WASHINGTON, D.C. 20301

1. The purpose of this report is to provide a summary of the results of the research conducted during the period from July 1, 1959, to June 30, 1960.

2. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

3. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

4. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

5. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

6. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

7. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

8. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

9. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

10. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

11. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

12. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

13. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

14. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

15. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

16. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

17. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

18. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

19. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

20. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

21. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

22. The research was conducted in the field of the study of the effects of the environment on the behavior of the human subject.

23. The results of the research indicate that the environment has a significant effect on the behavior of the human subject.

61080 JUL 29 1987

FOR
STATE
REGISTRAR

Mary M. Rozanek

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20065

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY M. MIDDLE ROZANEK LAST			2a. DATE OF DEATH MONTH 07 DAY 25 YEAR 87		2b. HOUR 0630 M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 12 DAY 12 YEAR 94		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CZECHOSLOVAKIA	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE MD.			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST VINCENT MIDDLE LAST KREPELKA			15. MOTHER'S MAIDEN NAME FIRST ANTONIA MIDDLE LAST NOVOTNA		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-48-8081		17. INFORMANT ADDRESS LUDMILA ROZANEK 1505 POPLAND ST. BALT. MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SPONTANEOUS</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>RECURRENT SEIZURES</u>					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6-18</u> , 19 <u>87</u> , to <u>7-25</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7-24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Robert R. Ramirez</u>				22c. DATE SIGNED 7-25-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT R. RAMIREZ				22e. ADDRESS SOUTH BALTIMORE GEN. HOSP. S. HANOVER ST BALT. MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/28/87	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.
24. FUNERAL DIRECTOR NAME George J. Gonce		ADDRESS 4001 Ritchie Hgwy. Balto. Md.		25a. DATE REC'D. BY REGISTRAR JUL 27 1987	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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059774 JUL 15

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20060

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>Eloise K Rush</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>7-12-87</u>			2b. HOUR M <u></u>				
3. SEX <u>Female</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>7-10-14</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u>		6. IF UNDER 1 YEAR MONTHS DAYS <u></u>		
7a. BIRTHPLACE (STATE OR FOREIGN) <u>FLA.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO. CITY</u> MD.				
10. CITY OR TOWN OF DEATH <u>BALTO.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>719 Radnor Ave</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u></u>		
13a. STATE <u>MD.</u>			13b. COUNTY <u>BALTO.</u>		13c. CITY OR TOWN <u>BALTO.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>719 Radnor Ave #21212</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>George King</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Lula McPherson</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u></u>				
16b. SOCIAL SECURITY NO. <u>21524-6597</u>			17. INFORMANT <u>Arthur Rush</u>			ADDRESS <u>719 Radnor Ave #21212</u>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) SUDDEN DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last(b) HYPERTENSION

DUE TO, OR AS A CONSEQUENCE OF

(c) APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

CAUTION HOMOSEXUAL INTERCOURSE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u></u> P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) this hospital attended the deceased from <u>19 85</u> to <u>7/11</u> , 19 <u>87</u> , that (b) (we) last saw the deceased alive on <u>JUNE 10, 19 87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If we did not last see the body after death).							
22b. SIGNATURE <u>Charles Haent</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>8/13/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>7/16/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Herbertus Memorial</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR NAME ADDRESS <u>Betts Funeral Home 1129 N. Caroline ST</u>				25a. DATE REC'D. BY REGISTRAR <u>JUL 14 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Jana Anderson</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then place in the space provided on page 3 the name of the funeral home, the name of the funeral director, and the name of the funeral home. This certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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WIND



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20061

REG. NO.

1 - FOR
STATE
REGISTRAR

59908 JUL 17 1987

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR M
JAMES				RUSINEK	JULY 10, 1987	3:40P
3. SEX	4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YEAR MONTHS DAYS
Male	White		Nov. 13, 1987		70	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MD	
Md.	USA				Baltimore City	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Church Hospital		unknown			
13a. STATE				13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Md.					Baltimore	13e. STREET ADDRESS / ZIP CODE 824 S. Kenwood Ave. 21224
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
Gaborel		Rusinek		Anna		
				Unknown		
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No		213-05-6576 Josephine Rusinek 824 S. Kenwood Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC CANCER OF THE LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
				JULY 01 19 87 to JULY 10 19 87		
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 01</u> , 19 <u>87</u> , to <u>JULY 10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>JULY 10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Beena Najpal		DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEENA NAJPAL		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL		July 14/1987		Holy Rosary Cem.		Balto. MD.
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John N. WEBER & Sons Inc.		JUL 16 1987		Julia Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRED		FIRST Russell		MIDDLE Russell		LAST Russell		2a. DATE OF DEATH MONTH DAY YEAR July 19, 1987		2b. HOUR 5:59 A					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5/25/25		6. AGE (IN YEARS LAST BIRTHDAY) 62		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS HOURS MIN. 5:59 A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Florida		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.									
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1810 McCulloh St. 21217							
14. FATHER'S NAME FIRST MIDDLE LAST ? ? ?				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 146-14-6236		17. INFORMANT ADDRESS Marilyn Clayton 533 W. Lafayette Ave. (17)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) Left consolidation and Atelectasis															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c) Left Lung Mass															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that the (this hospital) attended the deceased from July 15, 1987 to July 19 , 19 87 , that we (we) last saw the deceased alive on July 19 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) not view the body after death.															
22b. SIGNATURE C. Ravi						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-20-87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chaitanya Ravi, M.D.						22e. ADDRESS c/o Maryland General Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/22/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Lansdowne A.A. Md.		25a. DATE RECD. BY REGISTRAR							
24. FUNERAL DIRECTOR Chas. A. Rice FSPA 1300 Eutaw Pl.						25b. REGISTRAR'S SIGNATURE JUL 23 1987									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anthony Joseph Rybikowsky, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 7/01/87		7b. HOUR M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 10/04/14		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5708 Simmonds Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Belvedere
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Kasparas Rybikowsky		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frazina Bintonin		13e. STREET ADDRESS / ZIP CODE 5708 Simmonds Avenue 21215	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-05-2425		17. INFORMANT Mrs. Helen Rybikowsky 5708 Simmonds Avenue Baltimore Maryland 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Pancreas DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes mellitus, Chronic obstructive Airway Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from November 19 86 to 6-30 19 87 , that (I) (we) last saw the deceased alive on 6-30 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.					
22b. SIGNATURE GARY A. MANKO MD				22c. DATE SIGNED 7-2-1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY A. MANKO MD				22e. ADDRESS Suite 5, 11E Chestnut Hill Ln, Rockersstown, Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/4/87		23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Stokesville Carroll MD					
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc 8728 Liberty Road Randallstown Maryland 21133				25a. DATE REC'D. BY REGISTRAR JUL 06 1987 25b. REGISTRAR'S SIGNATURE Julia Tindon-Randall	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20070

1. DECEASED NAME (TYPE OR PRINT) THEODORE W. RYLAND			2a. DATE OF DEATH MONTH DAY YEAR JULY 24, 1987			2b. HOUR 8:00 AM		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 31, 1915			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICIAN		12b. KIND OF BUSINESS OR INDUSTRY AMSTAR		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 616 WOODSDALE ROAD 21228
14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL E. RYLAND			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMMA HULTS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ANNE M. RYLAND			ADDRESS SAME AS # 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/26 1986 to 7/24 1987, that (II) (we) last saw the deceased alive on 7/17 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Patrick W. White M.D.						22c. DATE SIGNED 7/24/87		22d. ADDRESS 299 FREDERICK ROAD, BALTIMORE, MD. 21228
22e. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICK WM. WHITE M.D.			22f. ADDRESS 299 FREDERICK ROAD, BALTIMORE, MD. 21228					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7/27/87		23c. NAME OF CEMETERY OR CREMATORY MOST HOLY REDEEMER		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME LEROY M. & RUSSELL C. WITZKE			24b. FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228			25a. DATE REC'D. BY REGISTRAR JUL 27 1987		25b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20071

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Rinalda SACCA</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>07-31-87</i>		2b. HOUR HOURS MIN. <i>02 10 PM</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>02-14-1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>66 YRS</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Italy</i>	7b. CITIZEN OF WHAT COUNTRY? <i>ITALY</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>City</i> MD.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>FRANKS Scott Key Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>House</i>
13a. STATE <i>MD</i>		13b. COUNTY <i>Calvert</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Americo Panella</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Armata</i>		16. SOCIAL SECURITY NO. <i>219-38-9955</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		17. INFORMANT <i>Mr. Salvatore Sacca</i>		ADDRESS <i>301 S. EAST AVE 21224</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO Pulmonary arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>146-5</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe Abdominal Bleed</i>		<i>146 hrs</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>unknown</i>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>7-30-87</i> , 19 <i>87</i> , to <i>7-31-87</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>7-31</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Stephen J. Noga</i>				22c. DATE SIGNED <i>7-31-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen J. Noga</i>				22e. ADDRESS <i>600 N Wolfe St + real. Rm 3-127 Oncology cell</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>8-3-87</i>	23c. NAME OF CEMETERY OR CREMATORY <i>OAKLAND CEMETARY</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i>
24. FUNERAL DIRECTOR NAME <i>Joseph N. ZANNINO JR.</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 3 1987</i>	25b. REGISTRAR'S SIGNATURE <i>Julia...</i>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

001219 AUG-48

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The other pages should be removed and retained by the funeral director. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MEVELYN SADDLER					2a. DATE OF DEATH MONTH DAY YEAR 7 9 87					2b. HOUR 6:45 AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 02 29 1924			6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.					13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Jack Creech					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Williams					16. STREET ADDRESS / ZIP CODE 734 Hollow Rd. 21043	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 218-32-0294		17. INFORMANT ADDRESS Wayland Saddler 734 Hollow Road Ellicott City, Md. 21043				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) yetastatic small cell carcinoma lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/9/87 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/9/87 , 19 87 , to 7/9 , 19 87 , that (I) (we) last saw the deceased alive on 7/8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dr. Daniel Lao</i>					DEGREE MD			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Daniel Lao					22e. ADDRESS St Agnes Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/11/87		23c. NAME OF CEMETERY OR CREMATORY Crestlawn			23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Ho. Md.			
24. FUNERAL DIRECTOR HARRY H. WITZKE					4112 Columbia Rd. Ellicott City, Md. 21043			25a. DATE REC'D. BY REGISTRAR JUL 13 1987			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>											

BP

060696

JUL 27 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

20073

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances R. Salisbury			2a. DATE OF DEATH MONTH DAY YEAR July 23, 1987		2b. HOUR 2:25 PM		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 7-4-12		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt. M.D.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD	
10. CITY OR TOWN OF DEATH Balt		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton Hosp + Med Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		13e. STREET ADDRESS / ZIP CODE 3111 Mareco Avenue 21213			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 218-03-4470		17. INFORMANT ADDRESS 3448 Roland Ave. Charles Salisbury (husband) 21211	
--	--	---	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lower Respiratory Infection DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Organic Brain Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days year year	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-20-87 to 7-23-87, that (I) (we) last saw the deceased alive on 7-23-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rolando V. Goco, MD						22c. DATE SIGNED 7-23-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rolando V. Goco, MD						22e. ADDRESS 707 E. Fort Ave, Balt, Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/23/87		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213				25. DATE RECEIVED BY REGISTRAR JUL 24 1987			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

080000 JUL 25 61

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059980

JUL 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

0 045 88 77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be submitted to the State Department of Health and Mental Hygiene within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tab on papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VMA 15, 4)

Film G629, 7/17/87
per FH, SB, Item 5, 6

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20074
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		A-	
EVELYN L. SAMPSON		JULY 11TH, 1987		3:09 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Black	MONTH DAY YEAR 11 22 23 24	62	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	USA		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	THE JOHNS HOPKINS HOSPITAL				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Md.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		13e. STREET ADDRESS / ZIP CODE	
George Stevens		Lelia Porter		21205 1401 Odessa Thomas Ct. Apt. 6	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Barbara Harris 1216 Edison Highway 21213	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSION</u>					4 min.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>POSSIBLE SEPSIS</u>					5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal failure; chronic obstructive pulmonary disease</u>					5 days
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
5/21/87	Necrotizing fasciitis	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital) attended the deceased from 5/19 1987, to 7/11 1987, that (I (we) lost saw the deceased (live or above) (I (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE	22c. DATE SIGNED		
Barry K. Rayburn, MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	7/11/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
Barry K. Rayburn		600 N. WOLFE ST., BALTO MD, 21205		Johns Hopkins Hospital	
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	7/16/87	Arbutus Memorial	Arbutus, Md.		
24. FUNERAL DIRECTOR		25. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H 1101 E. North Ave.		JUL 16 1987		Johns Hopkins Hospital	

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058977 JUL

Items, 18a, 21b, -22a., G-629, 7/25/87, by STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

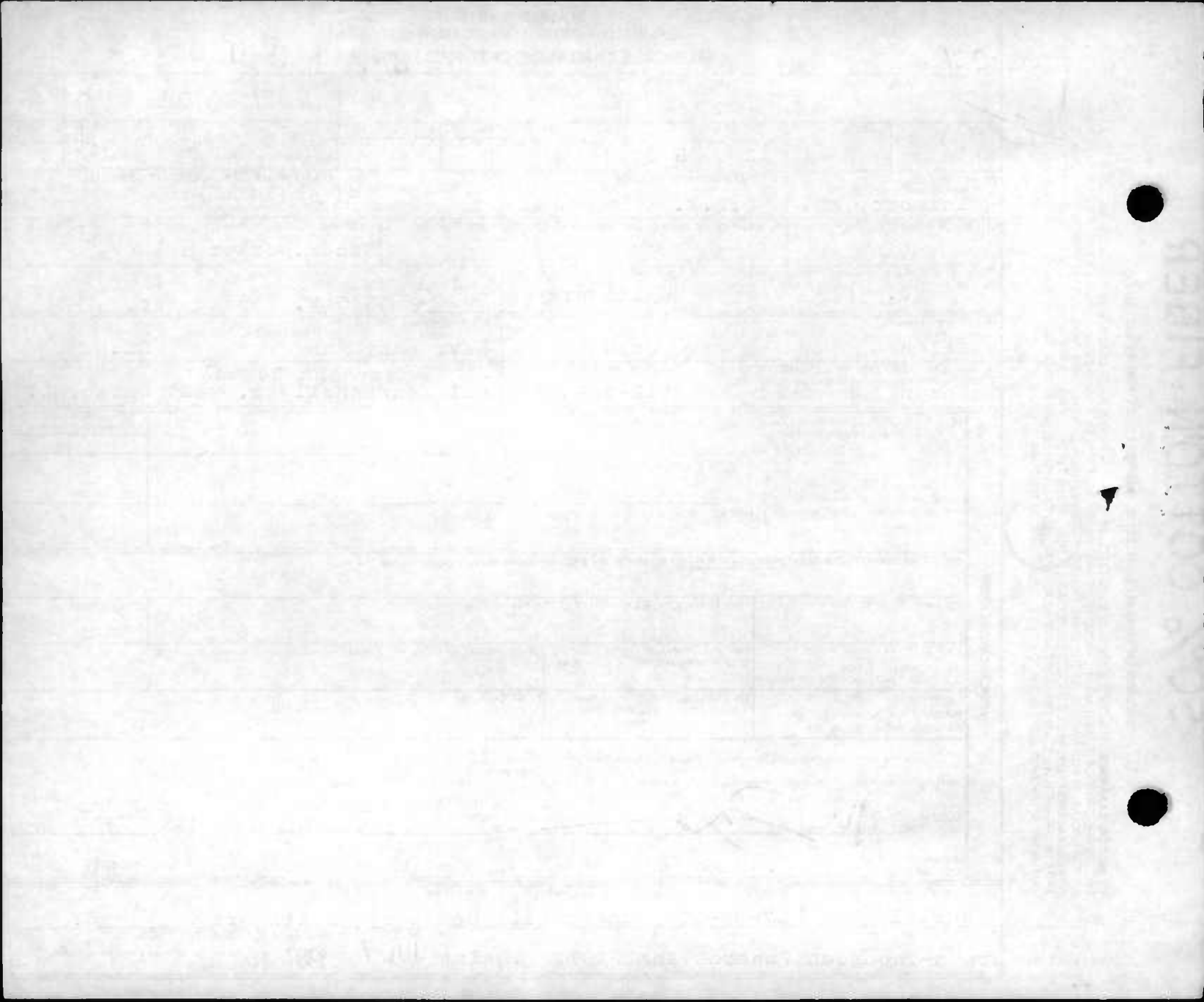
20075

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE KNOWN OF ESTI-MATED DEATH			2c. DATE PRONOUNCED DEAD			2d. DATE KNOWN OF DEATH			2e. DATE PRONOUNCED DEAD		
FIRST MIDDLE LAST Albert Samuel			MONTH DAY YEAR 11 08 38			MONTH DAY YEAR 7-3-87			MONTH DAY YEAR 7-3-87			MONTH DAY YEAR 7-3-87			MONTH DAY YEAR 7-3-87		
1. SEX Male			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR.			7. IF UNDER 24 HRS.		
1. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 845 W. Fayette Street		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 845 W. Fayette Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Water Worker			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE Md.			13b. COUNTY		
13a. STATE Md.			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 845 W. Fayette St.			14. FATHER'S NAME Ralph		
14. FATHER'S NAME Ralph			15. MOTHER'S MAIDEN NAME Rev. Mary Ann			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unknown			16b. SOCIAL SECURITY NO. 212-36-4962			17. INFORMANT Mary Ann Samuel			17. ADDRESS 911 Lendenhall St. #414 Balto; MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotic intoxication DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 7 3 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject used drugs.											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 845 W. Fayette St. Baltimore. Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .																	
ACTUAL SIGNATURE 			TITLE (SPECIFY) Deputy Chief M.D. MEDICAL EXAMINER												DATE SIGNED 7-4-87		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., MD 21201														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 07-09-87			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.								
24. FUNERAL DIRECTOR NAME Brown-Thompson Funeral Home			ADDRESS 1913 W. Balt.			25a. DATE REC'D BY REGISTRAR JUL 7 1987			25b. REGISTRAR'S SIGNATURE 								

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (1))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20070

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

ODELIA

SANDERS

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

7

24

87

M

3. SEX

FEMALE

4. RACE

BLACK

5. DATE OF BIRTH

MONTH

DAY

YEAR

12

11

03

6. AGE (IN YEARS LAST BIRTHDAY)

83

YRS.

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

VA

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE CITY

MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

2010 WOLFE STREET

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

RETIRED - restaurant

12b. KIND OF BUSINESS OR

INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

BALTIMORE

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

2010 Wolfe Street 21213

14. FATHER'S NAME

FIRST

MIDDLE

LAST

WILLIAM

CUFFEE

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

SARAH

ALLEN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

17. INFORMANT

218-18-1580

ADDRESS

WILLIAM CUFFEE 1319 E. BIDDLE ST.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardiac arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Normal pressure hydrocephalus

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from Oct. 19 86 to Nov. 19 87, that (I) (we) last
saw the deceased alive on Oct 16 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Chi-Shing Chu

DEGREE

MD

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

CHI-SHING CHU

22e. ADDRESS

100 N. Broadway, Belton MD 21231

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

BURIAL

23b. DATE

7/29/87

23c. NAME OF CEMETERY OR CREMATORY

MT CALVARY CEM

23d. LOCATION
CITY OR TOWN

ANNE ARUNDEL CO.

COUNTY

STATE

MD

24. FUNERAL DIRECTOR

NAME

WM C MARCH F/H

ADDRESS

1101 E. NORTH AVE.

25a. DATE REC'D BY REGISTRAR

JUL 28 1987

25b. REGISTRAR'S SIGNATURE

Julia Decker-Randall

081555 JUL 30 87

20% COTTON FIBER

MAINTAINED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by letter.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME. (Print last name first) FIRST MIDDLE LAST WILLIAM L. SANDERS			2a. DATE OF DEATH MONTH DAY YEAR 7 8 87		2b. HOUR 11 ⁵⁵ AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 6 27 22		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Odd Jobs
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William M. Sanders		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny M. Tolle		13e. STREET ADDRESS / ZIP CODE 1713 W. Lombard Street 21223	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 215-18-9667		17. INFORMANT ADDRESS Gordon A. Ward 1011 Wilmington Ave. 21223	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke, probably apoplexy</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pancreatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 6/24 87 7/8 87 19 87	
22a. I certify that (I) (this hospital) attended the deceased from 7/8 87, to 7/8 87, that (I) (we) last saw the deceased alive on 7/8 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. M. M. D.				22c. DATE SIGNED 7/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. M. M. D.				22e. ADDRESS BON SECOURS HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/10/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md.		24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229			
25a. DATE REC'D BY REGISTRAR JUL 10 1987				25b. REGISTRAR'S SIGNATURE Lisa Davidson-Randall	

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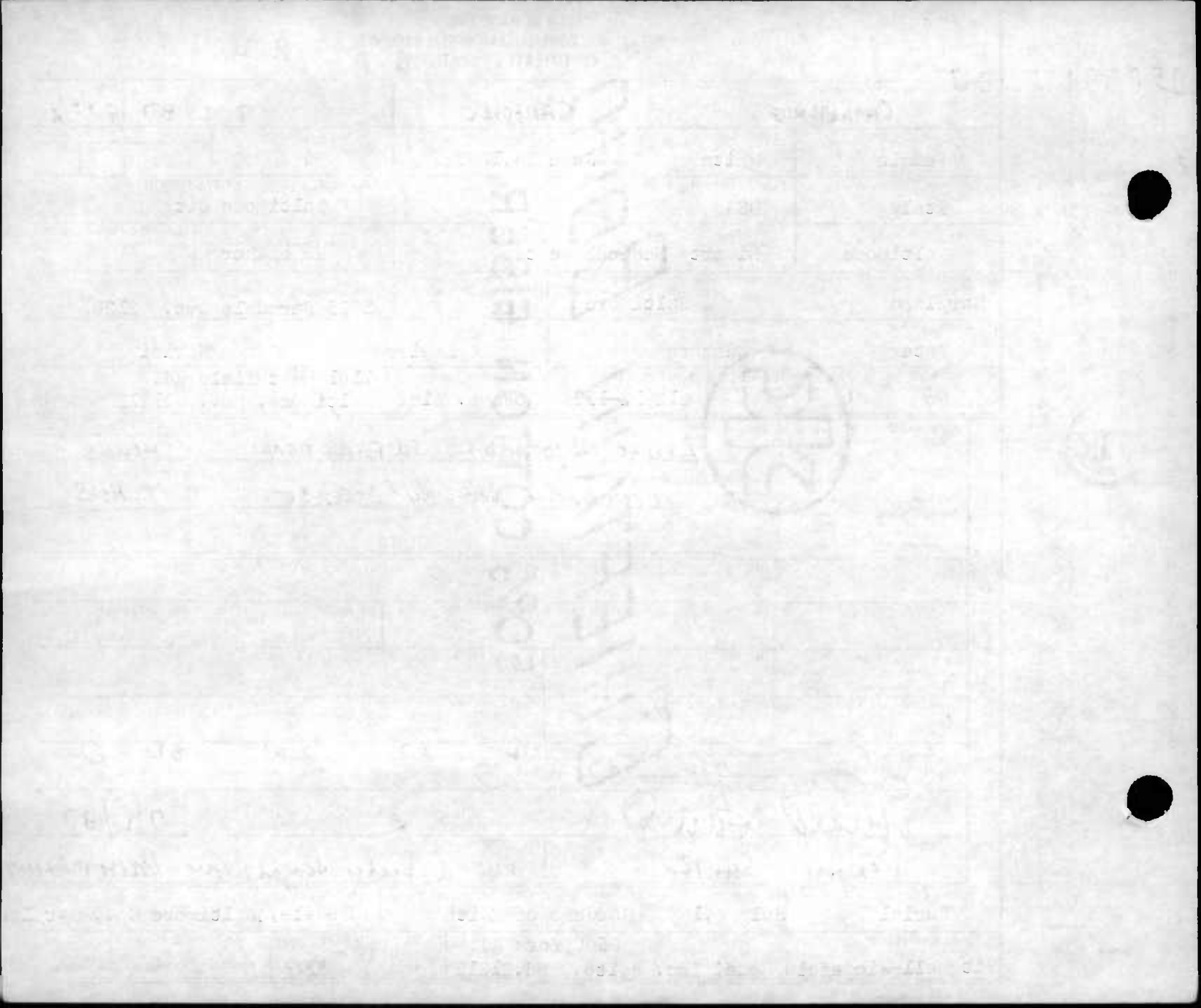
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20078

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CATHERINE			FIRST MIDDLE LAST SANTORI			2a. DATE OF DEATH MONTH DAY YEAR 7 2 87			2b. HOUR 9 48 AM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR June 24, 1893			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 94		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Peter Zazzbra			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Morisi			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 212-12-1529		
17. INFORMANT Rosa S. Aler			18. ADDRESS 7101 Heathfield Rd. Baltimore, Md.. 21212			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 7/2/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Ronald Sher			22c. DATE SIGNED 7/2/87			22d. PHYSICIAN'S NAME (TYPE OR PRINT) RONALD SHER		
22e. ADDRESS 2600 Liberty Heights Ave Balto Md 21207			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 6, 1987			23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		
23d. LOCATION CITY OR TOWN COUNTY STATE Overlea, Baltimore Co., Maryland			24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212			25a. DATE REC'D. BY REGISTRAR JUL 7 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		



060704 JUL 27 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 8720079
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLIS H. SAPP			2a. DATE OF DEATH MONTH DAY YEAR 7/18/87		2b. HOUR 6:30 A.M.
3. SEX MALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 07 19 1902		6. AGE (IN YEARS LAST BIRTHDAY) 88	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Patterson City MD	
10. CITY OR TOWN OF DEATH Patterson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH N. CHARLES GEN. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER	12b. KIND OF BUSINESS OR INDUSTRY TAILORING	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND			13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE APT. T-4 3443 CARRIAGE HILL CIR. #21133
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS SAPP			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE YANASHEVICH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 215-09-5043		17. INFORMANT DR. HAROLD GLAZER 2417 TANEY RD. BALTO., MD 21209	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Altered (6-87)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he/she) attended the deceased from <u>7/18 1987</u> , to <u>7/18 1987</u> , that (he/she) last saw the deceased alive on <u>7/18 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)			
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>7-18-87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Arthur M. Wernick MD</u>		22e. ADDRESS <u>NORTH CHARLES GEN. HOSP.</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JULY 20, 1987	23c. NAME OF CEMETERY OR CREMATORY TIFERETH ISRAEL	23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR JUL 24 1987	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. They please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. DEPARTMENT OF AGRICULTURE
NATIONAL AGRICULTURAL LIBRARY
WASHINGTON, D.C. 20503

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

20080

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
BESSIE			SATTERFIELD			7 26			19 87			M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
FEMALE		BLACK		11 09 1910		76 YRS.						7 27 19 87		9:50 A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
N. CAROLINA				U. S. A.								Baltimore City MD.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore				2334 Pennsylvania Ave.													
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MARYLAND						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Baltimore, Maryland 2334 Pennsylvania Ave. 21217							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
John Horton						Eva											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
No.				220-02-8561				Mrs. Louise M. Brooks				Baltimore, Md. 409 Edsdales Rd. 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
				Deputy Chief				MEDICAL EXAMINER				7-28-87					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Ann M. Dixon, M.D.				111 Penn St., Balto., MD				21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				7/31/1987		Arbutus Memorial Park				Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
The Bailey Funeral Home				1348 N. Calhoun St. Baltimore, Md. 21217				AUG 05 1987									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FCIM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 20081

REG. NO.

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE OF DEATH		KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/>		MONTH		DAY		YEAR		2b. HOUR	
		Russell						Savory		7/ 23/ 19 87				7/		23/		19 87		9:30 a M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		24 HOUR	
M		B 2		6 22 34		53 YRS.						7/ 23/ 19 87		7/		23/		19 87		9:30 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
UNKNOWN		U.S.A.				Baltimore City, MD.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		215 N. Spring Court		UNEMPLOYED		N/A															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1001 N. BROADWAY 21205													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
UNKNOWN		UNKNOWN																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
NO		N/A		DAISY JACKSON		1001 N. BROADWAY															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Alcoholism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
				DUE TO, OR AS A CONSEQUENCE OF																	
				(b)		DUE TO, OR AS A CONSEQUENCE OF															
				(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		HEAD ONLY		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
		P.M. 19																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		Dennis F. Smyth, M.D.		TITLE (SPECIFY)		Assistant MEDICAL EXAMINER		DATE SIGNED		7/23/87											
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn St.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE											
BURIAL				MT ZION CEMETERY		LANDSDOWNE,				MD											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
WM. C. MARCH F/H INC.		AUG 04 1987		Lisa Jordan-Rodgers																	
NAME		ADDRESS																			
1101 E. NORTH AVE.																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25A

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(VR A15 ME (1))

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AUG 04 1987

060403 JUL 23 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 87

20082
REG. NO.FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Selma Mary SCALES-WHITLOW			2a. DATE OF DEATH MONTH DAY YEAR 7 19 87			2b. HOUR 1015 AM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 19 36		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY Toy Mfg.	
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN Scales			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN UNKNOWN			13e. STREET ADDRESS / ZIP CODE 1627 Parkman Avenue, 21230			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1956-1957		17. INFORMANT Elvin A. Whitlow, 1627 Parkman Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurrent ventricular arrhythmias</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial infarction</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Congestive heart failure; hypothyroidism</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (a) (this hospital) attended the deceased from <u>July 19, 1987</u> to <u>July 19, 1987</u> , that (a) (we) last saw the deceased alive on <u>July 19, 1987</u> , and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Barbara Socha, M.D.					DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/19/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara Socha					22e. ADDRESS 900 Caton Ave., Baltimore.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/23/87		23c. NAME OF CEMETERY OR CREMATORY Crownsville VA Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville A.A. Maryland		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave.					25. DATE RECD. BY REGISTRAR JUL 22 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please return the accompanying pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

080403 JUL 53 81

WATER TOWER

1200

WATER TOWER

1200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to interment, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified by the attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John D. Scarberry						2a. DATE OF DEATH MONTH DAY YEAR 7/3				2b. HOUR 2355 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Burner		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 930 Homestead St. X 21218	
14. FATHER'S NAME FIRST MIDDLE LAST L. L. Scarberry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Madison							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Dorothy E. Scarberry		930 Homestead St. 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardiovascular renal failure DUE TO, OR AS A CONSEQUENCE OF (c) cat cell carcinoma of lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:											
19a. DATE OF OPERATION -				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK -				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -				21f. LOCATION STREET CITY OR TOWN COUNTY STATE -			
22a. I certify that (I) (this hospital) attended the deceased from 6/25 , 19 87 , to 7/3 , 19 87 , that (I) (we) last saw the deceased alive on 7/3 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Breiner MD								DEGREE -		22c. DATE SIGNED 7/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) June Breiner, M.D.						22e. ADDRESS Union Memorial Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE July 6, 1987		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214						25a. DATE REC'D. BY REGISTRAR JUL 06 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pudell			

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH20084
REG. NO.1- FOR
STATE
REGISTRAR

DECEASED NAME (FIRST MIDDLE LAST) JOHN R. SCARDINA			2a DATE OF DEATH : MONTH DAY YEAR 07 14 87		2b HOUR 01:35 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 4 30	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	12b KIND OF BUSINESS OR INDUSTRY Gas Station	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b COUNTY Baltimore	13c CITY OR TOWN Lansdowne	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 303 5th Avenue 21227	
14. FATHER'S NAME FIRST MIDDLE LAST Augustus Scardina		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosaria Culotta			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	16b SOCIAL SECURITY NO. 216-24-6955	17. INFORMANT ADDRESS Delores Scardina 303 5th Ave. 21227			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes Mellitus</i>					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <i>Stephen Plautthatt</i>		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED 7/14/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS St. Agnes Hospital			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b DATE 7/14/87	23c NAME OF CEMETERY OR CREMATORY Security Process Crematory	23d LOCATION CITY OR TOWN COUNTY Catonsville Balto. Md		
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Avenue		25a DATE REC'D. BY REGISTRAR JUL 16 1987	25b REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

02888 JUL 17 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be secured within 24 hours after death. Page 1 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. The funeral director should file with the State Dept. of Health and Mental Hygiene a copy of this certificate, and a copy of the death certificate. IMPORTANT: If item 21 is marked or item 18 shows any other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										20085	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR	
GEORGE		L.				SCHECH		JULY 13, 1987		3:55 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		3- 14--26		61		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				BALTIMORE CITY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		Carpenter							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3537 Chesterfield Ave.		21213			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Edward		Schech		Katherine		Spiegel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT							
Yes		W.W.II		218-22-6824		Robert C. Schech		2611 Hoffman Mill Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min. 6 months.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> , 19 <u>87</u> , to <u>7/13</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/13</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
<u>Raymond T. Chung</u>		MD				7/13/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Raymond T. Chung		JOHNS HOPKINS HOSPITAL, BALTIMORE MD 21205									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Cremation		7-14-87		Security Process		Balto.				MD.	
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Schimmunek Funeral Home, Inc.		JUL 15 1987		<u>[Signature]</u>							
3331 Brehms Lane											
BALTO., MD. 21213											

BP _____

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TOLSON 07 11 1962

NOT TO BE

0061299 JUL 30 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20080

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES SCHELL			2a. DATE OF DEATH MONTH DAY YEAR July 26 1987			2b. HOUR 10:45 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 03 / 09 / 16		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med Ctr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Valentine Schell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Rodenberg					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-05-1562		17. INFORMANT ADDRESS Scott-Key Medical Center			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular anest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) respiratory anest DUE TO, OR AS A CONSEQUENCE OF (c) acute asthma attack							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Nancy Chang				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NANCY CHANG				22e. ADDRESS Francis Scott Key			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 7-27-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME State Anatomy Board Balto., Md.				25a. DATE REC'D. BY REGISTRAR JUL 29 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

081522 JUL 30 65

20% COTTON FIBER

TRUCK MAN BOND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. Important: If item 21 is marked or item 18 shows any injury or other condition, the medical examiner must be notified at once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other information, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

PORTANT

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 2:45 PM	
SHIRLEY A. SCHISLER								7-3-87			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5-9-1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.					
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3013 OAKCREST AVE.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3013 OAKCREST AVE. 21234			
14. FATHER'S NAME FIRST MIDDLE LAST HAROLD AUSTIN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RUTH PETTY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-28-8163		17. INFORMANT ADDRESS Mrs Linda R. Schisler - 3013 Oakcrest Ave 21234					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive pulmonary disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>											
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 19 80</u> to <u>July 19 87</u> , that (I) (we) lost saw the deceased alive on <u>June 23 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Charles M. Kerr MD</u>						DEGREE MD		22c. DATE SIGNED 7-6-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles M Kerr MD						22e. ADDRESS 6801 Belair Rd					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-7-87		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.			

18880

Charles A. Schuster

5-1-1932

F

RECEIVED

U.S.A.

2013 CARPENT AVE

Mr

U.S.A.

Harold A. Smith

211 26 610

No

Edward 12-7 87 Parkwood Co. Bldg No

100101

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON MED DR. KOKES PER MR. GREGORY

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Josephine Schloer				2a. DATE OF DEATH - MONTH DAY YEAR July 9, 1987		2b. HOUR 12:55A_M			
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 9 5 1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Hopkins Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Albert Ament		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Antkowiak		13e. STREET ADDRESS / ZIP CODE 2602 E. Fairmount Ave 21224					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-05-8528		17. INFORMANT ADDRESS Gerard Schloer 2602 E. Fairmount Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HyperTension, Diastolic Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 10-15 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Parotitis Adenoma									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 12/19 , 19 86 , to 7/30 , 19 87 , that (I) (we) lost saw the deceased alive on 6/15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE [Signature]		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-10-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Simon V. Sauer		22e. ADDRESS 2000 E. BALTO. ST.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/13/87		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS B. Dabrowski & Son 2818 E. Baltimore St.				25a. DATE REC'D. BY REGISTRAR JUL 13 1987				25b. REGISTRAR'S SIGNATURE	



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20089
REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
ANDREW Coker			SCHMIDT			7 2 1987			7 2 1987			6:45 A M							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			7d. HOUR							
Male	White	Sept. 1, 1922	64 YRS			7 2 1987			7 2 1987			6:45 A M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			U.S.A.			WIDOWED			DIVORCED			Baltimore City MD							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Baltimore			Union Memorial Hospital			Steel Worker			Steel Mfrgr.										
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md												--		Baltimore,		YES XX NO		4301 Falls Road 21211	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
John Schmidt						Mary Elizabeth Coker													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT							
Yes						WWII						219 18 6440							
												Rick Fitzhugh 2 Old Sound Rd. Joppatowne							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Cranio-Cerebral Trauma																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
DUE TO, OR AS A CONSEQUENCE OF																			
DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES XX NO							
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
6 7 2 1987				Subject in house that collapsed															
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				21g. CITY OR TOWN							
Home				4301 Falls Rd. Balto.				Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from																			
Natural causes Accident Suicide Homicide Undetermined manner																			
22b. I certify that I took charge of the remains described above, held on death resulted from																			
Natural causes Accident Suicide Homicide Undetermined manner																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Ann M. Dixon, M.D.				Deputy Chief				7-2-87											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS				111 Penn Street-Balto. Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				7/6/87				Parkwood Cemetery				Baltimore, Maryland							
24. FUNERAL DIRECTOR				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Burgee-Henss Funeral Home, 3631 Falls Rd 21211								JUL 7 1987				J. Henss							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

30% COTTON FIBER

MADE IN U.S.A.

MADE IN U.S.A.



Handwritten signature or mark.

058816

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH2.0090
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR							
Carl L. Schmidt						7-4-1987						5:55P							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD							
male		white		5 25 40		47 YRS.		MONTHS DAYS		HOURS MIN.		7-4-1987							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Baltimore				U.S.A.								Baltimore City MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore				Mercy hospital				unemployed											
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.														Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1239 Haubert St. 21230	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST				FIRST MIDDLE LAST															
Leon Schmidt jr.				Sophie Groleski															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
no				220-36-1615				Sophie Schmidt				1239 Haubert St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Aspiration of bolus of food complicating anoxic encephalopathy																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 7-4-1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
								Subject choked on food											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hospital				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Deaton Medical Center, 611 S. Charles St. Baltimore City, MD											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Ann M. Dixon, M.D.				M.D. Deputy Chief				7-5-87											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Ann M. Dixon, M.D.				111 Penn Street, Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial				7-8-87		Glen Haven Cem.				Brooklyn Md.									
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE							
Chas. L. Stevens Funeral Home						1501 Fort ave. Jul 8, 87													

INC.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

2000 COTTON CIBER

WINTER 1941

Rest

1941

058814 JUL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN THE SPACE PROVIDED. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20091

REG. NO.

FOR 1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
		Naomi Bell Schmidt					X	7	2	1987	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Female	White	December 26, 1920	69			7	2	1987	6:45	A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	U.S.A.			Balto. City		MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore	Union Memorial Hospital		Homemaker								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS							
Md	--	Baltimore		4301 Falls Road 21211							
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Clara Virginia Miller				Russell C. Hanna							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF YES, GIVE WAR OR DATES				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				220 14 0839		Rick Fitzhugh 2 Old Sound Rd Joppatowne, Md 21085					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				6 xxx 7 2 1987		Subject in house that collapsed					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				Home		4301 Falls Rd. Balto.		Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy Chief				DATE SIGNED			
				M.D.				7-2-87			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Ann M. Dixon, M.D.				111 Penn Street-Balto. Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				7/6/87		Parkwood Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Burgee-Henss Funeral Home, 3631 Falls Rd. 21211								JUL 7 1987			

07/84
25M

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DHMM - 17
(VR A15 ME (5))

PIECE MOTION 2002

DMD WHITEHEAD



061407

JUL 30 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

20092
REG. NO.1 - FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) LOUIS A LLEN SCHREIBER			7a DATE OF DEATH MONTH DAY YEAR 7 - 24 - 87		7b HOUR 6:40 P M
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8 19 28	6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY MERCY HOSPITAL		12a USUAL OCCUPATION (GIVE STREET OF WORKING PLACE) EXECUTIVE DIRECTOR	12b KIND OF BUSINESS OR INDUSTRY BALTO. HEBREW CONG.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTO	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 3514 BONFIELD RD 21208
14 FATHER'S NAME FIRST MIDDLE LAST HERMAN EDWARD SCHREIBER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN DAVID			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 220-20-2740	17 INFORMANT MRS. REGINA K. SCHREIBER 3514 BONFIELD RD. (21208)		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular tachycardia / Atrial fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Gastrointestinal hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH a) 3 hrs b) 12 hrs
--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Ischemic congestive cardiomyopathy

19a DATE OF OPERATION NA	19b CONDITION FOR WHICH OPERATION WAS PERFORMED NA	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) NA	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from July 1, 19 87, to July 24, 19 87, that (2) (we) lost saw the deceased alive on July 24, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did not view the body after death.			
22b. SIGNATURE Mark M. Applefeld MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/24/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK M. APPLEFELD, MD		22e. ADDRESS MERCY HOSP. 301 ST PAUL PLACE BALTO 21202	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b DATE JULY 26, 1987	23c. NAME OF CEMETERY OR CREMATORY BALTO. HEBREW CONG.	23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD
24 FUNERAL DIRECTOR NAME SOL LEVINSON		25a DATE REC'D. BY REGISTRAR JUL 31 1987	25b REGISTRAR'S SIGNATURE Julia Davidson-Randall

061407 JUL 30 67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

RELEASED AS NON-MED-DR. KOKES PER MR. FREEMAN 07/01/87

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) MARSHALL Jackson SCHROEDER Jr.					2a. DATE OF DEATH MONTH DAY YEAR JULY 1, 1987		2b. HOUR P M 2:16		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 6 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balt. MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2319 Ashland Ave., 21205	
14. FATHER'S NAME FIRST MIDDLE LAST Marshall Jackson Schroeder Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Cord				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMANT (Daughter) Lois C. Snyder		ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST DUE TO</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 mins	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RESPIRATORY FAILURE DUE TO</u>								3 hrs	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>								8 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>7-1-</u> 19 <u>87</u> , to <u>7-1-</u> 19 <u>87</u> , that (1) we last saw the deceased alive on <u>7-1-</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) we (we) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>					DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-1-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES L. BAKER MD					22e. ADDRESS JOHNS HOPKINS HOSP, BALTIMORE, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 3, 1987		23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Mariottsville, Howard MD			
24. FUNERAL DIRECTOR NAME Charlton Funeral Home					ADDRESS 22007 Eastern Ave.		25a. DATE REC'D. BY REGISTRAR JUL 7 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

BP

060250 JUL 22 1987

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 87

REG. NO. 20094

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Shirley

A.

Schuler

2a. DATE OF DEATH MONTH DAY YEAR
July 17, 1987

2b. HOUR

M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH 2-2-29^{AY} YEAR

6. AGE (IN YEARS LAST BIRTHDAY)

58

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

YRS

7a. BIRTHPLACE (STATE OR FOREIGN
COUNTRY)

Balto., MD

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD

10. CITY OR TOWN OF DEATH

Baltimore City

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

4032 Raymonn Ave., Balto. 21213

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Operator

12b. KIND OF BUSINESS OR
INDUSTRY

C.&P. Telephone

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

13c. CITY OR TOWN

Balto. City

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE

4032 Raymonn Ave., Balto. 21213

14. FATHER'S NAME

Dorsey

MIDDLE

LAST

Berger

15. MOTHER'S MAIDEN NAME

Clara

MIDDLE

LAST

LeBonn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

220-20-6893

17. INFORMANT

ADDRESS

Nelson J. Schuler, Sr., 4032 Raymonn Ave.

Balto., MD 21213

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Oat Cell Lung Cancer

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 10 Oct 19 86 to present 19 87, that (we) lost
saw the deceased alive on June 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIAN ☒MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☐

22c. DATE SIGNED

7/17/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

LARRY WATERBURY, MD

22e. ADDRESS

FSK Med. Center

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

7-20-87

23c. NAME OF CEMETERY OR CREMATORY

New Cathedral

23d. LOCATION
CITY OR TOWN

Balto.

COUNTY

Balto., MD

24. FUNERAL DIRECTOR

John C. Miller, Inc., 6415 Belair Rd. 21206

25a. DATE REC'D. BY REGISTRAR

JUL 21 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

080520 JUL 55 01

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST COVAS S. SCHULTE					2a. DATE OF DEATH MONTH DAY YEAR JULY 08, 1987		2b. HOUR 12:20 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 26 1929		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 57		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank Officer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4402 Anntana Ave. 21206	
14. FATHER'S NAME FIRST MIDDLE LAST Carl B. Sherred				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel M. McLannahan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-24-8413		17. INFORMANT ADDRESS Charles A. Schulte 4402 Anntana Ave. 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CANCER OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8 JUNE 26, 19 87 , to JULY 8, 19 87 , that (I) (we) lost saw the deceased alive on JULY 8, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Beena Najpal						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEENA NAJPAL				22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jul 9 1987		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 13 1987		25b. REGISTRAR'S SIGNATURE Gina Winder-Randall			

BP _____



061193 JUL 29 87

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR		REG NO	
2- DECEASED NAME (LAST OR FIRST) MIDDLE LAST		3- DATE KNOWN OF DEATH ESTI-MATED	
Alfred Herman Schultz, Jr.		7/ 23/ 19 87	
4- SEX	5- RACE	6- DATE OF BIRTH MONTH DAY YEAR	7- AGE (IN YEARS LAST BIRTHDAY)
Male	White	1 31 10	77 YRS.
8- BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9- CITIZEN OF WHAT COUNTRY?	
Maryland		United States	
10- CITY OR TOWN OF DEATH		11- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Baltimore		4413 Moravia Rd. Apt. 10	
12- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a STATE		13b COUNTY	
Maryland		Baltimore	
14- FATHER'S NAME FIRST MIDDLE LAST		15- MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Alfred Herman Schultz, Sr.		Bertha Neidemeyer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
no		216-03-0930	
17- INFORMANT ADDRESS		18- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
Mrs. Helen Rabinek 22021 4317 Lees Corner Rd. Chantilly, VA.		PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease	
		(b) DUE TO, OR AS A CONSEQUENCE OF	
		(c) DUE TO, OR AS A CONSEQUENCE OF	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Margarita A. Korell, M.D.		Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Margarita A. Korell, M.D.		7/25/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		7/28/87	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Oaklawn Cemetery		Baltimore MD.	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D BY REGISTRAR	
Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133		JUL 28 1987	
		25b. REGISTRAR'S SIGNATURE	
		[Signature]	

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

001103 JUL 20 1961

REBIRTH MOTION PICTURE

DOWN
MAY 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The lower portion of this death certificate is to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The complete certificate, including pages 1 and 2, should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to taking final disposition, or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, the medical examiner must be notified and a postmortem examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 20097			
FOR Film #G629, Item #13e 1- STATE & 17, 7/22/87, sjb REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7a. DATE OF DEATH		7b. HOUR A M	
HARRY L. SCHULTZ, JR.				JULY 07, 1987		3:51 A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	White	June 28, 1919	68 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	U.S.A.		BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	THE JOHNS HOPKINS HOSPITAL		Veterinarian		Animal Medicine		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE			
Maryland	Baltimore	Towson	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1103 Cawdor Ct. 1103 Cawdor Ct.		21204	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Harry L. Schultz, Sr.		Esther Claub					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes		WW II		Anna M. Schultz - same as #13e		1103 Cawdor Ct. 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic malignant melanoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1987</i> to <i>July 7, 1987</i> , that (I) (we) lost saw the deceased alive on <i>July 7, 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Philip Keiser</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>7/7/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KEISER</i>				22e. ADDRESS THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST., BALTO., MD. 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Entombment		7-9-87		Dulaney Valley Maus.		Cockeysville, Balto., Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ruck Towson Funeral Home, Inc., Towson, Md. 21204				1050 York Rd. JUL 08 1987		<i>John R. Ruck</i>	

BP

[illegible]

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

87 20098

REG. NO.

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

WILLIAM

SCHULTZ

2a. DATE KNOWN OF DEATH ☒ 2b. HOUR 8 M

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

Jan. 29, 1922

6. AGE (IN YEARS)

65 YRS.

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

7-24-87

2d. HOUR 6:15a

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Germany

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

1012 Hollins Street

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Distributor

12b. KIND OF BUSINESS OR INDUSTRY

Wholesale

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

--

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1249 Woodbourne Ave. 21239

14. FATHER'S NAME

Adam

MIDDLE

Schultz

LAST

15. MOTHER'S MAIDEN NAME

Elizabeth

MIDDLE

Jane

LAST

Hepden

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

WWII

17. INFORMANT

217-16-6355

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

Mrs. Elsie M. Grunewald, 8 Sonya Ct

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a).

Arteriosclerotic cardiovascular disease

DUPLICATE OF OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last.

(b)

DUPLICATE OF OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY (HEAD ONLY) YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE

Mario F. Golle, Jr.

TITLE (SPECIFY)

Assistant MEDICAL EXAMINER

DATE SIGNED 7-24-87

EXAMINER'S NAME (TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

111 Penn Street

ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

7/27/87

23c. NAME OF CEMETERY OR CREMATORY

Moreland Memorial

23d. LOCATION CITY OR TOWN

Baltimore

COUNTY

Maryland

24. FUNERAL DIRECTOR

Lemmon-Mitchell-Wiedefeld, 10 W. Padonia RD.

25a. DATE REC'D BY REGISTRAR

JUL 27 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

POSS 12

000010 JUL 58 81

ROY COTTON FIBER

WILKINSON



058756

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERICK ANDRE SCOTT		2. DATE KNOWN OF DEATH EST. MATED 7-5-87		3. DATE OF DEATH MONTH DAY YEAR 7-5-87		4. HOUR 4:40A	
5. SEX male	6. RACE black	7. DATE OF BIRTH MONTH DAY YEAR 1 24 1965	8. AGE (IN YEARS) LAST BIRTHDAY 22 YRS.	9. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	10. IF UNDER 24 HRS. HOURS MIN.	11. DATE PRONOUNCED DEAD MONTH DAY YEAR 7-5-87	12. HOUR 4:40A
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		14. CITIZEN OF WHAT COUNTRY? U S A		15. MARRIED WIDOWED NEVER MARRIED DIVORCED		16. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City	
17. CITY OR TOWN OF DEATH Baltimore		18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) University Hospital		19. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		20. KIND OF BUSINESS OR INDUSTRY	
21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. STREET ADDRESS 1713 Gertrude Street 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Ozell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Hunt		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-84-0650	
17. INFORMANT Donna Thompson		ADDRESS 1713 Gertrude Street		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound to right buttock DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 12:32A 7-5-87 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) street		21f. LOCATION 3000 blk. Westwood Ave. Balto., Maryland			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) Assistant		MEDICAL EXAMINER		DATE SIGNED 7-6-87	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/9/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		23d. LOCATION CITY OR TOWN Arbutus	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR JUL 7 1987		25b. REGISTRAR'S SIGNATURE Julia Tindon-Rodgers			

07/84
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(VR A15 ME (15))

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Mr. J. H. Smith

July 1, 1900

060752 JUL 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20709

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Quinn Scott			2a. DATE OF DEATH MONTH DAY YEAR July 21 1987		2b. HOUR 5:30P M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 14 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Quinn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS / ZIP CODE 7956 Eastdale Rd., Balto. 21224			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-03-3572		17. INFORMANT ADDRESS Roger Scott, 7956 Eastdale Rd. 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) End Stage Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Urosepsis, Lung Carcinoma							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 15 19 87 to July 21 19 87 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 21 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did (did not) view the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCEL ZUGHAYR MD		22e. ADDRESS C/O Maryland General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/24/87		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Md.	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.		ADDRESS 6500 York Rd. Balto., Md 21212		25a. DATE REC'D. BY REGISTRAR JUL 24 1987		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1/1/61

FOR
STATE
ISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO. 1

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE KNOWN OF DEATH		3. DATE OF ESTI-MATED		4. MONTH		5. DAY		6. YEAR		7. HOUR		8. MINUTE	
Theodore		Scott						7/ 24/ 19 87		7/ 24/ 19 87											
9. SEX		10. RACE		11. DATE OF BIRTH		12. AGE (IN YEARS LAST BIRTHDAY)		13. IF UNDER 1 YR.		14. IF UNDER 24 HRS.		15. DATE PRONOUNCED DEAD		16. MONTH		17. DAY		18. YEAR		19. HOUR	
MALE		BLACK		6 2 45		42 YRS.		MONTHS		DAYS		7/ 24/ 19 87		MONTH		DAY		YEAR		1:04 P M	
20. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		21. CITIZEN OF WHAT COUNTRY?		22. MARRIED		23. NEVER MARRIED		24. WIDOWED		25. DIVORCED		26. BALTIMORE CITY OR COUNTY OF DEATH		27. BALTIMORE CITY		28. BALTIMORE CITY		29. BALTIMORE CITY		30. BALTIMORE CITY	
MARYLAND		USA		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		BALTIMORE CITY		BALTIMORE CITY		BALTIMORE CITY		BALTIMORE CITY		BALTIMORE CITY	
31. CITY OR TOWN OF DEATH		32. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		33. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		34. KIND OF BUSINESS OR INDUSTRY		35. BALTIMORE		36. JOHN L. DEATON MEDICAL CENTER		37. N/A		38. N/A		39. N/A		40. N/A		41. N/A	
39. STATE		40. COUNTY		41. CITY OR TOWN		42. INSIDE CITY LIMITS?		43. STREET ADDRESS		44. 805 N. CHESTER STREET		45. 21205		46. 805 N. CHESTER STREET		47. 21205		48. 805 N. CHESTER STREET		49. 21205	
MD		BALTO.		BALTO.		YES		NO		805 N. CHESTER STREET		21205		805 N. CHESTER STREET		21205		805 N. CHESTER STREET		21205	
50. FATHER'S NAME		51. MOTHER'S MAIDEN NAME		52. FATHER'S NAME		53. MOTHER'S MAIDEN NAME		54. FATHER'S NAME		55. MOTHER'S MAIDEN NAME		56. FATHER'S NAME		57. MOTHER'S MAIDEN NAME		58. FATHER'S NAME		59. MOTHER'S MAIDEN NAME		60. FATHER'S NAME	
THEODORE		ELIZABETH		THEODORE		ELIZABETH		THEODORE		ELIZABETH		THEODORE		ELIZABETH		THEODORE		ELIZABETH		THEODORE	
61. WAS DECEASED EVER IN U.S. ARMED FORCES?		62. SOCIAL SECURITY NO.		63. INFORMATION		64. ADDRESS		65. MRS. ELIZABETH SCOTT		66. 130 AISQUITTH ST.		67. 2FL		68. MRS. ELIZABETH SCOTT		69. 130 AISQUITTH ST.		70. 2FL		71. MRS. ELIZABETH SCOTT	
NO		N/A		MRS. ELIZABETH SCOTT		ADDRESS		130 AISQUITTH ST.		2FL		2FL		130 AISQUITTH ST.		2FL		2FL		130 AISQUITTH ST.	
72. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		73. PART 1 DEATH WAS CAUSED BY:		74. IMMEDIATE CAUSE (a)		75. DUE TO, OR AS A CONSEQUENCE OF		76. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.		77. (b)		78. DUE TO, OR AS A CONSEQUENCE OF		79. (c)		80. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		81. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		82. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Head Injuries with Complications		Head Injuries with Complications		Head Injuries with Complications		Head Injuries with Complications		Head Injuries with Complications		Head Injuries with Complications		Head Injuries with Complications		Head Injuries with Complications		Head Injuries with Complications		Head Injuries with Complications		Head Injuries with Complications	
83. DATE OF OPERATION		84. CONDITION FOR WHICH OPERATION WAS PERFORMED?		85. AUTOPSY?		86. YES		87. NO		88. YES		89. NO		90. YES		91. NO		92. YES		93. NO	
83. DATE OF OPERATION		84. CONDITION FOR WHICH OPERATION WAS PERFORMED?		85. AUTOPSY?		86. YES		87. NO		88. YES		89. NO		90. YES		91. NO		92. YES		93. NO	
94. EXTERNAL CAUSE WAS		95. TIME OF INJURY		96. HOW INJURY OCCURRED		97. ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		98. 7:27 P.M.		99. 5/ 26/ 19 85		100. subject was assaulted in 1985		101. 7:27 P.M.		102. 5/ 26/ 19 85		103. subject was assaulted in 1985		104. subject was assaulted in 1985	
94. EXTERNAL CAUSE WAS		95. TIME OF INJURY		96. HOW INJURY OCCURRED		97. ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		98. 7:27 P.M.		99. 5/ 26/ 19 85		100. subject was assaulted in 1985		101. 7:27 P.M.		102. 5/ 26/ 19 85		103. subject was assaulted in 1985		104. subject was assaulted in 1985	
105. INJURY OCCURRED		106. PLACE OF INJURY		107. LOCATION		108. CITY OR TOWN		109. COUNTY		110. STATE		111. 1400 Blk. Ashland Ave., Baltimore City, Md.		112. 1400 Blk. Ashland Ave., Baltimore City, Md.		113. 1400 Blk. Ashland Ave., Baltimore City, Md.		114. 1400 Blk. Ashland Ave., Baltimore City, Md.		115. 1400 Blk. Ashland Ave., Baltimore City, Md.	
105. INJURY OCCURRED		106. PLACE OF INJURY		107. LOCATION		108. CITY OR TOWN		109. COUNTY		110. STATE		111. 1400 Blk. Ashland Ave., Baltimore City, Md.		112. 1400 Blk. Ashland Ave., Baltimore City, Md.		113. 1400 Blk. Ashland Ave., Baltimore City, Md.		114. 1400 Blk. Ashland Ave., Baltimore City, Md.		115. 1400 Blk. Ashland Ave., Baltimore City, Md.	
116. I certify that I took charge of the remains described above, held on		117. Autopsy		118. Inspection		119. Inquiry		120. and in my opinion		121. death resulted from		122. Natural causes		123. Accident		124. Suicide		125. Homicide		126. Undetermined manner	
116. I certify that I took charge of the remains described above, held on		117. Autopsy		118. Inspection		119. Inquiry		120. and in my opinion		121. death resulted from		122. Natural causes		123. Accident		124. Suicide		125. Homicide		126. Undetermined manner	
127. ACTUAL SIGNATURE		128. M.D.		129. ASSISTANT		130. MEDICAL EXAMINER		131. DATE SIGNED		132. 7/25											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

NOTE TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. RETAIN PAGE 4. RETAIN PAGE 5 FOR YOUR FILES. **NOTE TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

DHMH - 17
(VR A15 ME (5))

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059301 J42 13 87

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 20102

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST XXXX Joseph DOY Patrick SCOWCROFT			2a. DATE OF DEATH MONTH DAY YEAR JULY 5, 1987		2b. HOUR A 11:42M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 3, 1987	6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 03		IF UNDER 1 YEAR IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None	12b. KIND OF BUSINESS OR INDUSTRY None	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia			13b. COUNTY Warren	13c. CITY OR TOWN Front Royal	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 32 West 17th Street, 22630
14. FATHER'S NAME FIRST MIDDLE LAST James Richard Scowcroft		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kathryn Ann Waggoner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS James & Kathryn Scowcroft, Front Royal, Va.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hypotension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>atrioventricular block, complete</u>		<u>1 1/2 hours</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Rashkind procedure</u>		<u>1 1/2 hours</u>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>pulmonary atresia with intact septum</u>			
19a. DATE OF OPERATION <u>7/5/87</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pulmonary Atresia</u>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/3/87</u> , 19 <u>87</u> , to <u>7/5</u> , 19 <u>87</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>7/5</u> , 19 <u>87</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.			
22b. SIGNATURE <u>Orin Kavanaugh-McHugh</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <u>7/5/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ORIN KAVANAUGH-McHUGH</u>		22e. ADDRESS <u>600 WOLFE ST BALTIMORE 21205</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 8, 1987	23c. NAME OF CEMETERY OR CREMATORY <u>Gardens</u>	23d. LOCATION CITY OR TOWN COUNTY STATE Manassas, Pr. William, VA.
24. FUNERAL DIRECTOR NAME <u>Donnell L. Smith</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 10 1987</u>	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rudner</u>

RELEASED AS NON-MEDICAL DR. DIXON PER MR. PURVIS ON 7/05/87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 3, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked (other), 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16-60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

2-24 1950

60801 JUL 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20103

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LETHA L. SEALS			2a. DATE OF DEATH MONTH DAY YEAR 7-18-87		2b. HOUR 3:50pm
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 1-31-1926		6. AGE (IN YEARS LAST BIRTHDAY) 61 yrs.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Francis Scott Key Med. Cen.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. STATE		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Owens		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-24-1618		17. INFORMANT ADDRESS 21234 Letha Weigert 8350 Edgedale Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-20</u> 19 <u>87</u> to <u>6-26</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>6-26</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dorcas H. Odom-Smith MD</u>		22e. ADDRESS <u>2601 E. Monument St. 21205</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-21-87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.
24. FUNERAL DIRECTOR Schumnek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md 21213		25a. DATE REC'D. BY REGISTRAR JUL 24 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED JUL 23 1981

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20104

1. FOR
STATE
REGISTRARDECEASED NAME
(OR PRINT)

FIRST

MIDDLE

LAST

SEK IDA

SEKULOW

2a. DATE OF DEATH MONTH DAY YEAR

7/15/87

2b. HOUR

2 P.M.

3. SEX

FEMALE

4. RACE

White

5. DATE OF BIRTH

8 27 05

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

RUSSIA

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Sinai Hospital

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY

AT HOME

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13b. STATE

MD

13c. COUNTY

13d. CITY OR TOWN

Baltimore

13e. INSIDE CITY LIMITS?

YES ☐ NO ☐

13f. STREET ADDRESS / ZIP CODE

6316 Greenspring Ave

APT. 104 #21209

14. FATHER'S NAME

FIRST

MIDDLE

LAST

ABRAHAM

HURWITZ

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

REBECCA

UNKNOWN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

216-28-2069

17. INFORMANT

M. R. ERWIN SEKULOW

3407 MIDFIELD RD. BALTO., MD 21208

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Aspiration of Secretions

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

hypoxia - acute bronchitis

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

? sepsis

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on 7/19/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)

19 87, to 7/15/87, that (I) (we) last

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

7/15/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Rohit Bhethnagar

22e. ADDRESS

SINAI HOSP. - BALTO., MD

21215

23a. BURIAL, CREMATION, REMOVAL

REMOVAL/BURIAL

23b. DATE

JULY 17, 1987

23c. NAME OF CEMETERY OR CREMATORY

MOUNT LEBANON

23d. LOCATION

ISELIN

COUNTY

NEW JERSEY

24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC.

6010 REISTERSTOWN RD. BALTO., MD

21215

25a. DATE REC'D. BY REGISTRAR

JUL 21 1987

25b. REGISTRAR'S SIGNATURE

Julia Denden-Rudman

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JUL 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

20105

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH SERGENT			2a. DATE OF DEATH MONTH DAY YEAR JULY 24, 1987		2b. HOUR 11:30pm
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 1, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (OR OF WORK FOR MOST OF WORKING LIFE) Salesman	12b. KIND OF BUSINESS OR INDUSTRY Automobile	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Ison P. Sergeant			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Drusiller Craft		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 233 22 8393	17. INFORMANT ADDRESS Nannie Alice Sergeant, Wife Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GRAM NEGATIVE SEPSIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) PSEUDOMONAS PNEUMONIA					
DUE TO, OR AS A CONSEQUENCE OF (c) LYMPHOPROLIFERATIVE DISORDER					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JUNE 24 , 19 87 , to JULY 24 , 19 87 , that (I) (we) last saw the deceased alive on JULY 24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>C. P. Belani</i>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHANDRA P. BELANI				22e. ADDRESS CHURCH HOSPITAL, BALTIMORE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Burial)		23b. DATE 7/28/87	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk.		23d. LOCATION CITY Howard Co., Md. STATE
24. FUNERAL DIRECTOR <i>Brzezinski Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR JUL 27 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20106

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Edna I. Sewell					7/23/87				11:20 ^{MA}
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Black		8/25/16		70		MONTHS		DAYS	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Baltimore, City				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		(Home) 2000 Odell Ave. Apt. 622									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2000 Odell Ave. Apt. 622 (37)		21237	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
George W. Queen		Bessie S. Queen									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No				Evelyn N. Hale		2607 Llewellyn Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		AZOTEMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		CERVICAL/VAGINAL CANCER							
		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
John L. Currie		MD		7/24/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
JOHN L. CURRIE		600 N. WOLFE ST. BALTO MD 21205									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		7/28/87		Westview Mem. Pk,		Catonsville				Md.	
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Chas. A. Rice FSPA 1300 Eutaw pl.		JUL 31 1987		Julia Bender-Landau							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 20107

1. DECEASED NAME (TYPE OR PRINT) FIRST ELSIE MIDDLE A. LAST SHAMLEFFER <i>Elsie A. Shanleffer</i>		2a. DATE OF DEATH MONTH 7 DAY 8 YEAR 87		2b. HOUR 10 45 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 4 DAY 8 YEAR 05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorton South		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY
13a. STATE MD.		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Frank MIDDLE Lidinsky LAST Lidinsky		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Horn LAST Horn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-03-5426		17. INFORMANT EDGAR SHAMLEFFER (HUSBAND) ADDRESS SAME ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from April 19 86 , to July 8 19 87 , that (1) (we) lost saw the deceased alive on July 8 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>John Tygant</i>		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tygant		22e. ADDRESS 3001 S. Harrow St. Balt, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/11/87		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK	
23d. LOCATION CITY OR TOWN BALTIMORE		COUNTY MD		STATE	
24. FUNERAL DIRECTOR NAME SCHUMER FUNERAL HOME INC. ADDRESS 3331 Brehms Lane, Balto. Md. 21213				25a. DATE REC'D. BY REGISTRAR JUL 10 1987	
				25b. REGISTRAR'S SIGNATURE <i>Richard R...</i>	

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CHIEF OF POLICE
CITY OF NEW YORK

RE: GIP MOTO

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 20108

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Olive L. Shaw			2a. DATE OF DEATH MONTH DAY YEAR 7 7 1987			2b. HOUR 1:45 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 26 1893		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Villa St. Michaels Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rental Agent		12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Oliver Campbell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lovella Bogges		13e. STREET ADDRESS 4800 Seton Drive		21215	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 494-40-6530		17. INFORMANT Thaddeus H. Gilbert		ADDRESS Timonium, MD. 122 East Padonia Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SMOKING</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>CBS, DJD, CHRONIC UTI</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-7</u> 19 <u>87</u> , to <u>7-7</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>7-7</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. C. Enrique, M.D.</u> DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. ENRIQUE, M.D.				22e. ADDRESS 2435 W. BELVEDERE AVE 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-11-87		23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Kansas City, Jackson, Missouri	
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service				ADDRESS Upperco, MD.		25a. DATE RECD. BY REGISTRAR JUL 15 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Landau			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use on the burial transit permit. Then please remove carbon pages 4 and 5 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH20109
REG. NO.

2a. DATE OF DEATH MONTH DAY YEAR 07 21 87		2b. HOUR 00:45 A	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 20, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 79 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bowie, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife-Homemaker	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William O. Seitz	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine --- Heer	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 217-48-9750		17. INFORMANT Miss Janet O. Shears - Daughter 301 Lee Drive-Catonsville, Md. 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Nephrotic Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 7/7 19 87, to 7/21 19 87, that (he) (was) (not) last saw the deceased alive on 7/20 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.			
22b. SIGNATURE Shanti Ramesh		DEGREE Resident Physician	22c. DATE SIGNED 7/21/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHANTI RAMESH		22e. ADDRESS St. Agnes Hospital 900 Caton Ave, Baltimore, MD 21229	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/24/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery-Baltimore, Maryland	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR Sterling Funeral Estate, P.A. 736 Edmondson Ave.; Catonsville, Md. 21228		25a. DATE REC'D. BY REGISTRAR JUL 22 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon and return page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to inquire.

BP

000225 JUL 23 87

TO: Mr. J. Edgar Hoover
FROM: Mr. [illegible]
SUBJECT: [illegible]

Re: [illegible]
[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO. 2 8 1 1 0

1. DECEASED NAME (Type or Print) LUTHER Eugene SHEELER Sr.			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 13 19 87		2b. HOUR M 3:56 P 3:56
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sep. 4, 1944	6. AGE (IN YEARS) (LAST BIRTHDAY) 42 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Key Medical Center	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction		12b. KIND OF BUSINESS OR INDUSTRY Gas-Utility		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13b. STREET ADDRESS Sparks 21152		13c. CITY OR TOWN Balto.		13d. STREET ADDRESS 14505 A. Thornton Mill Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Howard Leroy Sheeler, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Baublitz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 215-40-2297		17. INFORMANT Mrs. Martha J. Sheeler, 14505A Thornton		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Ann M. Dixon</i>		TITLE (SPECIFY) Deputy Chief		DATE SIGNED 7-14-87	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St. Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7-17-87		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto. Md.		24. FUNERAL DIRECTOR NAME ADDRESS J. E. Lowell Lemmon, 10 W. Padonia RD.		25a. DATE REC'D. BY REGISTRAR JUL 16 1987	
25b. REGISTRAR'S SIGNATURE <i>J. E. Lowell Lemmon</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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JUL 29 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

20111

1. DECEASED NAME FIRST MIDDLE LAST George E. Sheffield			2a. DATE OF DEATH MONTH DAY YEAR 7/26/87		2b. HOUR 2:35 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 03/01/45	6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive	12b. KIND OF BUSINESS OR INDUSTRY H. Co. Transp.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 1621 S. Hanover St. Balto. Md.	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Sheffield, Sr.	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Elizabeth Schultz		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN		
16a. SOCIAL SECURITY NO. 212163806		17. INFORMANT Mrs. Rose Shifield, Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Progressive Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>possible sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Candida pyelonephritis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs prior to admission 7 mos prior to admission
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Severe DKA, gm negative UTI, prolonged hospitalization</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/24</u> 19 <u>87</u> to <u>7/26</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/26</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)					
22b. SIGNATURE Jenny Petitto		DEGREE MD		22c. DATE SIGNED 7/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jenny Petitto		22e. ADDRESS Mercy Hospital, Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/29/87	23c. NAME OF CEMETERY OR CREMATORY Crownsville Vet.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Md.	
24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Fort Ave.		25a. DATE REC'D BY REGISTRAR JUL 28 1987		25b. REGISTRAR'S SIGNATURE Julia B. [Signature]	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1. The first part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The second part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The third part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The fourth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The fifth part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The sixth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The seventh part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The eighth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made. The ninth part of the report is a summary of the work done during the last year. It is a very good summary and gives a clear picture of the progress made. The tenth part of the report is a detailed account of the work done during the last year. It is a very good account and gives a clear picture of the progress made.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director must complete pages 4 and 5 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 7		20112		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) VIRGINIA L. SHEHAN						2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
3. SEX F		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Aug. 17, 1928		6. AGE (IN YEARS (LAST BIRTHDAY)) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Holifox Co. N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2831 Clifton Ave. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Martin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO. 212-22-6392		17. INFORMANT ADDRESS James Shehan 2831 Clifton Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intracranial Bleeding DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension, Diabetes Mellitus									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-14-87 , 19 87 , to 7-14 , 19 87 , that (I) (we) last saw the deceased alive on 7-14 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sher A Hashmi MD						22c. DATE SIGNED 7-14-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHER A HASHMI						22e. ADDRESS 2600 LIBERTY HEIGHTS AVE BALTIMORE 21215 Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/18/87		23c. NAME OF CEMETERY OR CREMATORY Arbutus		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Loray D. Dyer, Jr. F.H. 4600 Liberty Heights Ave						25a. DATE REC'D BY REGISTRAR JUL 15 1987			
						25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudolph			

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061567 AUG 4 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When these remove carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any illness or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NEWTON J SHEKERJIAN					2a. DATE OF DEATH MONTH DAY YEAR 7 30 87					2b. HOUR 3:30 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 02 52		6. AGE (IN YEARS LAST BIRTHDAY) 84			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Refinisher			12b. KIND OF BUSINESS OR INDUSTRY Furniture		
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5805 Willowton Ave. 21239			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Shekerjian				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 255-36-9323		17. INFORMANT ADDRESS Phyllis A. Shekerjian, Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRAIN TUMOR</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours 5 Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE AD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 7/30/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEAN-PIERRE ISSA						22e. ADDRESS 6914 LACHLAN CIRCLE BALT MD 21239					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-3-87		23c. NAME OF CEMETERY OR CREMATORY Moreland			23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc., 5305 Haaford Rd.						25a. DATE REC'D. BY REGISTRAR JUL 31 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Rucker			

061267 AUG-4-87

Handwritten notes and stamps, including "COLLON RIBBE" and "DOW".

Handwritten notes and stamps at the bottom, including "JUL 31 1987" and "JUL 31 1987".

061743 AUG 5 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20114
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST ROBERT	MIDDLE D	LAST SHEWBRIDGE SR.	2a. DATE OF DEATH MONTH DAY YEAR 7/30/87		2b. HOUR 1:45 PM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 12/15/1927		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WELDER		12b. KIND OF BUSINESS OR INDUSTRY STEEL			
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3615 4TH ST 21255			
14. FATHER'S NAME FIRST MIDDLE LAST ELMER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH RKE		ADDRESS 3615 4TH ST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 2 230-20-518		17. INFORMANT JANET SHEWBRIDGE BALTO 21255				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CORONARY ATHEROSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: BRONCHOPNEUMONIA								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (he) (this hospital) attended the deceased from July 29, 19 87, to July 30, 19 87, that (we) (we) lost saw the deceased alive on July 30, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Bert F. Morton M.D.					22c. DATE SIGNED 7/30/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERT F. MORTON					22e. ADDRESS St. Agnes Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-3-87	23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN mem		23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A. MD			
24. FUNERAL DIRECTOR NAME McCULLY FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR 237 PATARSCO ADDRESS BALTO. 21255		25b. REGISTRAR'S SIGNATURE AUG 4 1987				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-bonopaper. Page 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

061560 AUG -4 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20115

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET M. SHIMEK			2a. DATE OF DEATH MONTH DAY YEAR 7 29 87		2b. HOUR 8:45 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 10 17 15	6. AGE (IN YEARS LAST BIRTHDAY) 71		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.		
10. CITY OR TOWN OF DEATH Baltimore MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Office Worker		12b. KIND OF BUSINESS OR INDUSTRY A & P Inc.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		
13c. CITY OR TOWN Catonsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 228 E. Medwick Garth 21228					
14. FATHER'S NAME FIRST MIDDLE LAST George J. Shimek			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette Dubcak		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-01-74464		17. INFORMANT ADDRESS Dorothy Kohler 235 W. Medwick Garth 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). OVARIAN CANCER DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (s) (this hospital) attended the deceased from 1/10/87 to 7/29/87, that (s) (we) last saw the deceased alive on 7/29/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE Toby Rittenhoff MD				22c. DATE SIGNED 7/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TOBY RITTENHOFF				22e. ADDRESS UNIVERSITY OF MD HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/1/87		23c. NAME OF CEMETERY OR CREMATORY Bohemian Natl. Cem.	
23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25. DATE RECEIVED BY REGISTRAR JUL 30 1987	
26. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury or other traumatic event, the medical examiner must be notified and advised.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by a physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR		87 REG. NO. 20116	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Margaret Frances Shockley		MONTH DAY YEAR 7 13 87	
3. SEX Female		2b. HOUR 12:00 PM	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 74	
5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1913		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore City		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 947 Fairmount Ave. 21204			
14. FATHER'S NAME FIRST MIDDLE LAST Robert Claire		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-05-0546	
17. INFORMANT ADDRESS William R. Shockley - same as #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ventricular Tachycardia</u>		5.10mins	
(c) <u>Severe Ischemic Cardiomyopathy</u>		4wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Anemia</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) this hospital attended the deceased from <u>7-1</u> 19 <u>87</u> , to <u>7-13</u> 19 <u>87</u> , that (ii) (we) last saw the deceased alive on above, (i) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Joseph L. Raduazzo MD</u>		22c. DATE SIGNED 7-13-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph L. Raduazzo, M.D.		22e. ADDRESS The Union Memorial Hospital	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 7-16-87	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley		23d. LOCATION Cockeysville, Balto., Md.	
24. FUNERAL DIRECTOR Ruck Towson Funeral Home, Inc., Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR JUL 15 1987	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

BP

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JUL 27 87

REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH 8 /

REG. NO.

20111

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MORTON SHOR			2a. DATE OF DEATH MONTH DAY YEAR 7 21 87			2b. HOUR 5:25 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 22 19		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. XXXXX		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY OF BALTIMORE MD.	
10. CITY OR TOWN OF DEATH BALT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4112 KENSHAW AVE. (21215)				12a. USUAL OCCUPATION (TYPE AND PLACE FOR MOST OF WORKING LIFE) MECHANIC	
12b. KIND OF BUSINESS OR INDUSTRY AUTO REPAIR		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD. 13c. COUNTY BALTO 13d. CITY OR TOWN BALTO		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE 4112 KENSHAW AVE 21215	
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN SHOR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY SAKOL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE YEAR(S) DATE(S)) YES Army WWII 11/17/44 - 11/44			
16b. SOCIAL SECURITY NO. 214-14 9983		17. INFORMANT JOAN SHOR 4112 KENSHAW AVE. (21215) ADDRESS XXXXXXX XXX XXXX XXXXXXXXXXXXXXXX					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC PANCREATIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 86 , to July 19 87 , that (I) (we) lost saw the deceased alive on 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John A. Covington		DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. COVINGTON		22e. ADDRESS 300 ARMY PLACE BALT					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/23/87		23c. NAME OF CEMETERY OR CREMATORY BETH EL MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTO MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO, MD 21215				25a. DATE RECEIVED BY REGISTRAR JUL 24 1987		25b. REGISTRAR'S SIGNATURE John A. Covington	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions on page 3, it should be detached for use as the burial permit. The funeral director should place this certificate in the coffin with the deceased. The funeral director should also place this certificate in the coffin with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18, does any injury, other traumatic event, the medical examiner must be notified as usual.

BP _____

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ON

FILED

RECEIVED JUL 27 1981

John A. Cunningham, Jr.
1000 1st St. N.E.
Atlanta, GA 30309

JUL 27 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20118

FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MONTH DAY YEAR 7 20 1987 2b. HOUR M 6:25

1. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR Aug. 12 86 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 11 8 7. IF UNDER 1 YR. MONTHS DAYS 11 8 8. IF UNDER 24 HRS. HOURS MIN. 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 20 1987 2d. HOUR M 6:25

9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.

10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) --- 12b. KIND OF BUSINESS OR INDUSTRY ---

13a. STATE Maryland 13b. COUNTY --- 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS 209 S. Stricker Street 21223

14. FATHER'S NAME FIRST MIDDLE LAST Robert I. Shore, Sr. 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa E. Thompson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) --- 16b. SOCIAL SECURITY NO. 215-13-4927 17. INFORMANT ADDRESS Robert I. Shore, Sr., 209 S. Stricker St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). Sudden Infant Death Syndrome
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b).
DUE TO, OR AS A CONSEQUENCE OF
(c).

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion

ACTUAL SIGNATURE TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER DATE SIGNED 7-21-87

EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. ADDRESS 111 Penn St., Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 7/23/87 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A.A. Maryland

24. FUNERAL DIRECTOR NAME ADDRESS 21229 Hubbard Funeral Home, Inc., 4107 Wilkens Ave. 25a. DATE REC'D. BY REGISTRAR JUL 22 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

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THE ROYAL COLLEGE LIBRARY

WILKINSON

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to burials. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20119

FOR 1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) Arthur		FIRST Shorts		LAST		2a. DATE OF DEATH MONTH DAY YEAR July 20, 1987		2b. HOUR 2:09 AM	
3. SEX m		4. RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR 5 5 1912		6. AGE (IN YEARS (LAST BIRTHDAY)) 75 y 1		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS HOURS MIN. MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NIA -		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cats					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore Gen Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY UNKNOWN					
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1034 Hanover St Baltimore 21230			
14. FATHER'S NAME FIRST Clinton MIDDLE LAST Shorts		15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE (UNKNOWN) LAST (UNKNOWN)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 230-44-3789A		17. INFORMANT ADDRESS son - same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Urinary Tract Infection with pneumonia - pro										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Severe Dehydration with Renal Failure											
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Prostate with possible metastases											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Possible Septic Shock, Possible Liver metastasis, Antecoxal miasis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 3001 S. Hanover St Baltimore MD 21230		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/19 , 19 87 to 7/20 , 19 87 , that (I) (we) lost saw the deceased alive on 7/20 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE M. E. Rodriguez, M.D.						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. E. RODRIGUEZ, M.D.						22e. ADDRESS 3001 S. Hanover St Baltimore MD 21230					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-24-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Brown-Thompson F.H.						ADDRESS P.O. Box 4433		25a. DATE REC'D. BY REGISTRAR JUL 22 1987		25b. REGISTRAR'S SIGNATURE Julia J. Robinson-Randall	

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MEDICAL CERTIFICATION

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JUL 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO. 20121

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GORDON J. SHRIVER		2a. DATE OF DEATH MONTH DAY YEAR 7 18 87		2b. HOUR 1:15 PM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 12 19		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Beltz	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore G. Hosp. - Retired		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) trucking		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY BC	13c. CITY OR TOWN Beltz	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2904 Delaware Ave. 21227	
14. FATHER'S NAME FIRST MIDDLE LAST James Shriver		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unbach			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 21810654		17. INFORMANT ADDRESS Constance Shriver 2904 Delaware Ave. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure (acute)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Subhepatic Abscess</u> DUE TO, OR AS A CONSEQUENCE OF } (c) <u>Perforated duodenal ulcer.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ARDS</u>					
19a. DATE OF OPERATION 7/16/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Necrotic ischemic colon LEAKING GASTROINTESTINAL		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/04/87, 19, to 7/18/87, 19, that (I) (we) lost saw the deceased alive on 7/18/87, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Gordon		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JORDGE E. GORDON		22e. ADDRESS South Baltimore General			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/22/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
23d. LOCATION CITY OR TOWN Dorsey		COUNTY Howard		STATE Md.	
24. FUNERAL DIRECTOR NAME Ambrose, Inc. 1328 Sulphur Spr. Rd. 21227		ADDRESS		25a. DATE REC'D BY REGISTRAR JUL 21 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please transmit the death papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20122
6:55PM
1855PM

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Rosalia O. Shriver			MONTH DAY YEAR July 22 1987			1855PM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS
F	W	MONTH DAY YEAR 10 14 27		59 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD	U.S.A.				Baltimore MD			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore City			The Union Memorial Hospital			Nursing		Home
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS & ZIP CODE		
MD				BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	700 W. 40th St. - Home		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Mark Schriver			FIRST MIDDLE LAST Oliver					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
			212-28-6528		Union Memorial Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN - 18 S</u> <u>2 WEEKS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>C.O.P.D. NEUROFIBROMATOSIS</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>July 20</u> , 19 <u>87</u> , to <u>July 22</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>July 22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Eva S. Hersh M.D.</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>7/22/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eva S. Hersh, M.D.						22e. ADDRESS The Union Memorial Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Removal			7-23-87					
24. FUNERAL DIRECTOR NAME ADDRESS State Anatomy Board Balto., Md.						25a. DATE REC'D. BY REGISTRAR JUL 29 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>

BP _____

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1. STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Siegmund			2a. DATE OF DEATH MONTH DAY YEAR July 4 1987			2b. HOUR M M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec 15 1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 209 S. Washington St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY -----							

13a. STATE Maryland			13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 209 S. Washington St. 21231	
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14. FATHER'S NAME FIRST MIDDLE LAST Unknown Schoff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Unknown		
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS Joseph Siegmund, Jr. 209 S. Washington St. 21231	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

A.C.U. - CHF

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) Hypertension

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
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22a. I certify that (I) (this hospital) attended the deceased from 5/15 19 78 to 7/4 19 87, that (I) (we) lost saw the deceased alive on 6/24 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
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22b. SIGNATURE Joseph R. Schults MD			22c. DATE SIGNED 7/6/87		
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH R. SCHULTS, MD			22e. ADDRESS 3508 Brookside Rd., Baltimore, Md. 21224		
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/8/87		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
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24. FUNERAL DIRECTOR NAME Lilly & Zeiler, Inc. 1901 Eastern Ave. 21231		25a. DATE REC'D. BY REGISTRAR JUL 07 1987		25b. REGISTRAR'S SIGNATURE Julia F. Smith	
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. 20124

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERALDINE H. SILBERZAHN			2a. DATE OF DEATH MONTH DAY YEAR 7 21 87			2b. HOUR 625 AM		
3. SEX F		4. RACE W I		5. DATE OF BIRTH MONTH DAY YEAR 3 19 26		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.		
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED CTR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) L.P.N. - Good Sam. Hosp.		
13a. STATE Md.		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George T. Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda H. Missler		16. STREET ADDRESS / ZIP CODE 4115 Echodale Ave. 21206				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-28-1983		17. INFORMANT ADDRESS Edward C. Silberzahn Sr. 4115 Echodale Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL BLEED DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CARCINOMA OF LUNG								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE BALTO MD				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____ that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Barbara L. A. Herbert				DEGREE MD		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA L A HERBERT				22e. ADDRESS FSK MED CENTER 4940 EASTERN AVE BALTO MD 21224				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7-24-87		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS John C. Miller Inc. 6415 Belair Rd. 21206				25a. DATE REC'D. BY REGISTRAR JUL 23 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

000021-1 JUL 24 81

JUL 23 1981

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20125

1. DECEASED NAME (TYPE OR PRINT) Jill Elizabeth Simmons										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7 19 87		2b. HOUR M 5:55 PM	
3. SEX F		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1970		6. AGE (IN YEARS) (LAST BIRTHDAY) 16 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 19 87		2d. HOUR M 5:55 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital - STU				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student-Senior				12b. KIND OF BUSINESS OR INDUSTRY High School	
13a. STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Great Falls		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10700 Beech Mill Rd.					
14. FATHER'S NAME FIRST MIDDLE LAST Lawrence R. Simmons						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clarissa Greenwood							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230-29-0011		17. INFORMANT ADDRESS Lawrence R. Simmons 10700 Beech Mill Rd. Great Falls, Va.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8830 IMMEDIATE CAUSE (a) <u>Air Embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:00 7 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject was diving							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Millbrook Quarry		21f. LOCATION STREET CITY OR TOWN COUNTY STATE John Marshall Hwy. - Beverly, Va. - Prince Wm. Va.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 7-20-87					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M. D.				ADDRESS 111 Penn St., Balto. Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Removal				23b. DATE 7/23/87		23c. NAME OF CEMETERY OR CREMATORY Arnon Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Great Falls, Fairfax, VA			
24. FUNERAL DIRECTOR NAME J. Berkley Green				ADDRESS 721 Elden St. Herndon, VA				25a. DATE REC'D BY REGISTRAR JUL 22 1987				25b. REGISTRAR'S SIGNATURE Julia Borden-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THIS PAGE. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
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(VR A15 ME (1))

000240 JUL 23 81

RESEIN KOTTON 2400

WALFORD

Handwritten signature or initials

000240 JUL 23 81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon and return page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic with the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PEARL M. SIMMONS			2a. DATE OF DEATH MONTH DAY YEAR 7-12-1987			2b. HOUR PM 3:10				
3. SEX FEMALE		4. RACE CAUCASION		5. DATE OF BIRTH MONTH DAY YEAR 1 31 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 87		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BOSTON, MASS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTO. MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LAFAYETTE NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3707 Falls Road 21211	
14. FATHER'S NAME FIRST MIDDLE LAST (unknown) Towers			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 462-20-8789		17. INFORMANT ADDRESS John W. Simmons 3707 Falls Road 21211					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK - Prob. Septic DUE TO, OR AS A CONSEQUENCE OF (b) Recurrent UTI / Possible Appendicitis DUE TO, OR AS A CONSEQUENCE OF (c) WILKINSON'S DISEASE, OBS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a 1/2 GI Bleed. / Ascend / PUD										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:00 P.M. 7/12/1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-22-87 19 87 , to 7-12-87 19 87 , that (I) (we) last saw the deceased alive on 7-12-87 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE John W. Simmons			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/16/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Maryland			
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr.			ADDRESS 3818 Roland Ave. 21211			25a. DATE REC'D BY REGISTRAR JUL 15 1987			25b. REGISTRAR'S SIGNATURE [Signature]	

2028 COTTON FIBER

CHIEF A.M. DOWD



JUL 1 1934

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

20127
REG. NO.

FOR
1- STATE
REGISTRAR

2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-6-87 19			2b. HOUR M 6:39a		
3. SEX male			4. RACE black		
5. DATE OF BIRTH MONTH DAY YEAR 8 27 1961			6. AGE (IN YEARS) (LAST BIRTHDAY) 25 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md			7b. CITIZEN OF WHAT COUNTRY? U S A		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cunningham Asphalt Plant			12b. KIND OF BUSINESS		
13a. STATE Md			13b. COUNTY		
13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 3602 Old Frederick Road					
14. FATHER'S NAME FIRST MIDDLE LAST John P. Singleton, Sr			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara White		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 219-82-0693		
17. INFORMANT Barbara White			ADDRESS 3602 Frederick Road		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

8147 IMMEDIATE CAUSE (a) Head injuries
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6AM xxx 7-6-87 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by an auto	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3000blk. Edmondson Ave. Baltimore, Md.	

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 7-6-87

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/11/87		23c. NAME OF CEMETERY OR CREMATORY King Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown MD	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR JUL 7 1987		25b. REGISTRAR'S SIGNATURE <u>Jane Jones</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PLESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PLESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20128

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
LORETTA Regina Sinnott				7/2/87		7:45		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	Cauc.	10/10/1898		88 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Balto. Md.	U.S.			Balto. City				MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Balto. Md.	Deaton Hosp. & Medical Center		Retired						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3019 Oakcrest Ave. 21234	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
William Manning		Clara Healy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		213-74-8889		Wayne Sinnott		6678 Lochill Rd 21239			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Aspiration pneumonia								48 h	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Stages gastritis									
DUE TO, OR AS A CONSEQUENCE OF (c) Organic brain syndrome									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET					
22a. I certify that (I) (this hospital) attended the deceased from 4-9, 19 87, to 7-2, 19 87, that (I) (we) lost saw the deceased alive on 7-1-19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
B. VICIOSO, MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
B. VICIOSO, MD / FAMILY HEALTH				42 S. Greene St. 600 Regent St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial		7/6/87		New Cathedral Cemetery		Baltimore		Md.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS				JUL 7 1987		Julia Gordon-Randall			
Mitchell-Wiedefeld Home Inc. 6500 York Rd.									

2350

[Faint handwritten text]

Jan. 1900.

059009

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MICH 7

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

7-19

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Two please remove carbon papers. Pages 1 and 2 should be filed with the local health officer. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows trauma, injury, or other traumatic event, the medical examiner must be notified.

059009 34 MICH 7 DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST DELMER	MIDDLE G.	LAST SIZEMORE	2a. DATE OF DEATH JULY 6, 1987		2b. HOUR 12:05 P		REG. NO. 20129
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8-4-1920		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER.		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
13a. STATE Md.				13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 212 N. PORT ST. 21224	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE HAMILTON SIZEMORE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ICY IRENE PRITT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Wm. Ora M. Hayes - 212 N. Port St.		ADDRESS 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable Gastro intestinal Bleed.</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 min. 24 hours.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Alcohol abuse, alcoholic liver disease with coagulopathy</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/6</u> , 19 <u>87</u> , to <u>7/6</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/6</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Barry K. Rayburn, MD</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/6/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BARRY K RAYBURN</u>				22e. ADDRESS <u>Johns Hopkins Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>7-9-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GARRISON VETERANS</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO. Md.</u>			
24. FUNERAL DIRECTOR <u>Barth Miller - 2334 Jefferson St.</u>				25a. DATE REC'D. BY REGISTRAR <u>JUL 7 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Landman</u>			

BP

DHMH - 16 60M
(VRA 15, 1)

78-24755
GENERAL INVESTIGATIVE
DIVISION

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66	8-4-1120	W	M
100	X	U.S.A.	NEW YORK
215 N. EAST ST. 21524	X	BALTO.	MD.

GEORGE HAMILTON SIKEMANE ICA IRENE PRITT
WWT

215 N. EAST ST. 21524

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059990

JUL 20 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20130
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MANNIE J. SKETERS			MONTH 7 DAY 14 YEAR 87			1747 P.M.			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			
m	B L	MONTH 2 DAY 22 YEAR 1928	59 YRS.			MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
S.C.	USA				Baltimore City MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	St. Agnes Hosp			Retired					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			
Md						Baltimore			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			
FIRST MIDDLE LAST			FIRST MIDDLE LAST			250-405941			
Nearo			Classie			Nero			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO			250-405941			Annie Sketers			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
BRAINSTEM VASCULAR ACCIDENT									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			HYPERENSION						
DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
			HOUR A.M. MONTH DAY YEAR						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from			22b. SIGNATURE						
7/12, 1987, to 7/14, 1987, that (I) (we) lost saw the deceased alive on 7/14, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			DEGREE						
			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
KENNETH Williams			St. Agnes Hosp. 101						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			7/18/87		Arbutus Memorial Park		Arbutus COUNTY STATE MD		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H West 4300 Wabash Avenue			JUL 17 1987			Rendall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place in the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

022220 JUL 20 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20131
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Albert Charles Smith			2a. DATE OF DEATH MONTH DAY YEAR 7 4 87		2b. HOUR 0552M
3. SEX m	4. RACE w	5. DATE OF BIRTH MONTH DAY YEAR 9 16 936		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service Director		12b. KIND OF BUSINESS OR INDUSTRY Normandy Ford
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Linthicum	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Vincent Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Glee		13e. STREET ADDRESS / ZIP CODE 507 LaClaire Avenue, 21090	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-32-2580		17. INFORMANT ADDRESS Joan L. Smith, 507 La Claire Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 7-4 , 19 84 , to 7-4 , 19 87 , that (I) (we) last saw the deceased alive on 7-4 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.					
22a. SIGNATURE Grady S. Gordon				22c. DATE SIGNED 7-4-87	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Grady S. Gordon				22e. ADDRESS St. Agnes Hosp 21229	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/8/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Park A.A. Maryland		24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc., 21229 4107 Wilkens Ave.			
25a. DATE RECEIVED BY REGISTRAR July 8 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			

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61322 JUL 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20132

1. DECEASED NAME (TYPE OR PRINT) Catherine M. Smith			2a. DATE OF DEATH MONTH DAY YEAR 07 27 87			2b. HOUR 2 A.M.	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 06 11 10		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (CITY OR TOWN) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS Scott Key Med Ctr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME Charles		15. MOTHER'S MAIDEN NAME Katherine		16. SOCIAL SECURITY NO. 219-079638		17. INFORMANT ADDRESS 21239 Wilford Smith 1809 Woodbourne Ave.	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		18c. CITY OR TOWN BALTO.		18d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/26</u> 19 <u>87</u> , to <u>7/27</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE F. McMahon MD				DEGREE MD		22c. DATE SIGNED 7/27/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS McMAHON				22e. ADDRESS FRANCIS Scott Key Med. Ctr.			
23a. BURIAL, CREMATION, REMOVAL (CITY) BURIAL		23b. DATE 7-30-87		23c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEM.		23d. LOCATION CITY OR TOWN COUNTY BALTO. MD	
24. FUNERAL DIRECTOR NAME HOFFMANN-SKARDH				ADDRESS 3218 HUDSON ST.		25a. DATE REC'D. BY REGISTRAR JUL 30 1987	
				25b. REGISTRAR'S SIGNATURE James P. ...			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use on the burial transit permit. Then please remove this page and page 1 and 2 and place them in the folder with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must sign the death certificate.

BP

DHMH - 16 50M 1/81
(VA 15, 4)

081355 JUL 30 03

NOTION 6202
MAY 19 1964

061207 JUL 30 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20133

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			3. MONTH DAY YEAR			7b. HOUR		
Clinton Ambrose Smith			X			7 26 1987			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			7d. HOUR		
Male	White	11 17 27	59 YRS.	MONTHS	DAYS	7 26 19 87			2:40 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City, MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Ellwood Park-1230 S. Ellwood Ave.				Retired		Railroad			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS				
Md.			Baltimore		Dundalk		3444 McShane Way 21222				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. ADDRESS					
FIRST MIDDLE LAST			FIRST MIDDLE LAST								
			Smith			Mary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
Yes			1946-1947		214-24-8476 Tammy Radtke 3444 McShane Way 21222						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Lobar Pneumonia with abscess formation</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION					
						STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED					
Margarita A. Korell			M.D. Assistant MEDICAL EXAMINER			7-27-87					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
Margarita A. Korell			111 Penn St., Balto. Md. 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial			7-29-87		Maryland Veterans			Garrison, Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Charles S. Zeiler & Son Inc. 901 S. Conkling St.						JUL 29 1987			Julia Dendron-Radabaugh		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

061507 JUL 30 84

11 17 77

Section 1

Section 2

Section 3

Section 4

Section 5

Section 6

Section 7

Section 8

Section 9

Section 10

Section 11

Section 12

Section 13

061564 AUG 4 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO. 20134

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. The deceased remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury or other traumatic event, the medical examiner must be notified at once.

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elsie L. SMITH			2a. DATE OF DEATH MONTH DAY YEAR 07-25-87		2b. HOUR 2-40 AM	
1. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 06 93		6. AGE (IN YEARS LAST BIRTHDAY) 93		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto Md.		
10. CITY OR TOWN OF DEATH Balto Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD	13b. COUNTY Balto	13c. CITY OR TOWN CATONSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7114 Academy Rd Balto 21228		
14. FATHER'S NAME FIRST MIDDLE LAST Herman Knaiemburg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Hirsch				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 412-23-9567		17. INFORMANT From Front Sheet of chart		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Cerebro Vascular Accident. DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Infected gastrostomy site						
19a. DATE OF OPERATION -	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7-24-87 to 7-25-87 , that (I) (we) lost saw the deceased alive on 7-24-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Kiran J. Parikh		DEGREE MD		22c. DATE SIGNED 7/25/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIRAN J. PARIKH		22e. ADDRESS 42/3 Leeds Ave, Arbutus, MD 21227				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7-29-87	23c. NAME OF CEMETERY OR CREMATORY CHESTNUT GROVE		23d. LOCATION CITY OR TOWN COUNTY STATE MARYSVILLE PEPPER PA.		
24. FUNERAL DIRECTOR NAME JOHN M WEBER + SONS INC		ADDRESS 401 S CHESTER ST		25. DATE RECEIVED BY REGISTRAR JUL 31 1987		

MEDICAL CERTIFICATION

BP

1. The first part of the report is a summary of the work done during the last year. It covers the following points:

- (a) The progress of the research.
- (b) The results of the experiments.
- (c) The conclusions drawn from the work.

2. The second part of the report is a detailed account of the work done during the last year. It covers the following points:

- (a) The progress of the research.
- (b) The results of the experiments.
- (c) The conclusions drawn from the work.

3. The third part of the report is a summary of the work done during the last year. It covers the following points:

- (a) The progress of the research.
- (b) The results of the experiments.
- (c) The conclusions drawn from the work.

4. The fourth part of the report is a detailed account of the work done during the last year. It covers the following points:

- (a) The progress of the research.
- (b) The results of the experiments.
- (c) The conclusions drawn from the work.

5. The fifth part of the report is a summary of the work done during the last year. It covers the following points:

- (a) The progress of the research.
- (b) The results of the experiments.
- (c) The conclusions drawn from the work.

060636 JUL 24 87

Film G629 Item 2a 7/29/87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20135

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James O. Smith			2a. DATE OF DEATH MONTH DAY YEAR 7-19-87 7-20-87			2b. HOUR M 5				
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 23 30		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			12b. KIND OF BUSINESS OR INDUSTRY ELIDDEN CHEMICAL CO.	
10. CITY OR TOWN OF DEATH MARYLAND		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FORMAN				

13a. STATE MD.			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1328 Stonewood Rd. 21239		
14. FATHER'S NAME FIRST MIDDLE LAST Wm. Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-25-3672			17. INFORMANT ADDRESS Betty Smith 1328 Stonewood Rd. 21239					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic renal failure.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Accelerated hypertension.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--	--	--	--	--	---	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>K. Trent MD.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. TRENT MD				22e. ADDRESS 1205 402K RD. ST 14, LUTHERVILLE MD.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/24/87		23c. NAME OF CEMETERY OR CREMATORY Maryland National Cemetery Laurel		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel MD.			
24. FUNERAL DIRECTOR NAME Wm C Marchant				ADDRESS 1101 E. North Ave.		25. DATE REC'D BY REGISTRAR JUL 23 1987		26. REGISTRAR'S SIGNATURE <u>Julia Sanders-Landrum</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial transit permit. Then please remove carbon copy. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. Social examination may be required. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Social examination may be required.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 20136

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Jesse R. Smith2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
07 19 87 100 P.M.3. SEX M 4. RACE BLACK 5. DATE OF BIRTH MONTH DAY YEAR
09 02 18 6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.7a. BIRTHPLACE (COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
South Carolina U.S.A.9. BALTIMORE CITY OR COUNTY OF DEATH MD
10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) No. Charles Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BAR-TENDER 12b. KIND OF BUSINESS OR INDUSTRY BAR13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS / ZIP CODE 11-W. 20th STREET, BALTO, MD. 2121814. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
James Edward Smith George Anna Smith16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 216-09-3550 17. INFORMANT NAME ADDRESS
Eloise E. Smith (WIFE) 11-WEST 20-TH STREET, BALTO, MD. 2121818. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastrointestinal bleed
DUE TO, OR AS A CONSEQUENCE OF (b) Presumed ischemic colitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Severe peripheral vascular disease, ventricular ectopy

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☒ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 6/26 19 87, to 7/19 19 87, that (I) (we) last saw the deceased alive on 7/19 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)

22b. SIGNATURE DEGREE 22c. DATE SIGNED
D. Morris MD ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 7/19/8722d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS
Deborah Morris MD No. Charles Hospital23a. BURIAL, CREMATION, REMOVAL 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL July 24 87 East View Cemetery Baltimore MD.24. FUNERAL DIRECTOR NAME ADDRESS
STONEWALL STEWART, JR. (365) 1425-MARYLAND AVE, N.E. WASH, DC 20002 JUL 24 1987 REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DHMH - 16 60M 7/84
(VRA 15, 4)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20137

REG. NO.

1. FOR REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) ROBERT SMITH		2a. DATE OF DEATH MONTH DAY YEAR 8 1 72		2b. HOUR 40 M.	
3. SEX MALE		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 7 25 04		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16a. SOCIAL SECURITY NO. 212105992		17. INFORMANT ADDRESS Gladys Smith 2302 Guilford Ave. 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bulbar palsy DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)							
19a. DATE OF OPERATION 7/1/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Dysphagia / Incontinence		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:30 8 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART II OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) (this hospital) attended the deceased from 87 to 7/9 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)							
22a. SIGNATURE MAEN J. PARHA		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAEN J. PARHA		22e. ADDRESS Balt - MD - 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-14-87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARBUTUS MD	
24. FUNERAL DIRECTOR NAME MARCH FUNERAL HOMES		ADDRESS 1101 E. North Ave		25a. DATE REC'D. BY REGISTRAR JUL 13 1987		25b. REGISTRAR'S SIGNATURE Lila Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

10M 32B

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18a, 21a.-22a., G-629, 7/25/87, by STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20138

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH ESTIMATED		MONTH		DAY		YEAR		21. HOUR					
Ruth		Smith						6/29/87		6		29		87		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		22. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		23. HOUR	
FEMALE		BLACK		1-9-53		34 YRS.						6/29/87		6		29		87		6:14 a.m.	
70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		71. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH													
BALTIMORE CITY		U.S.		WIDOWED		DIVORCED		BALTIMORE CITY												30 MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
BALTIMORE		1018 McKean Ave.		UNEMPLOYED																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1018 McKean Ave.												21217	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
LEE		REBECCA (MAGWOOD)		NEVER		220-64-7925		JUANITA SMITH		1505 N. PATTERSON PARK AVE.											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Subdural Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>Unknown</u> 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Unknown</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .		22b. TITLE (SPECIFY) M.D. Assistant		DATE SIGNED <u>6/29/87</u>	
ACTUAL SIGNATURE <u>Dennis F. Smith</u>		EXAMINER'S NAME (TYPE OR PRINT) <u>Dennis F. Smith, M.D.</u>		ADDRESS <u>111 Penn St.</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>7-3-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTIMORE, MD</u>	
24. FUNERAL DIRECTOR NAME <u>RODNEY T. SYKES</u>		ADDRESS <u>4644 PIMLICO ROAD.</u>		25a. DATE RECD. BY REGISTRAR <u>7/1/87</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
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BP 657
DHMH - 17
(VR A15 ME (5))

20% COTTON FIBER

MADE IN U.S.A.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM MPM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20139

1. STATE REGISTRAR		CEASED NAME		FIRST	MIDDLE	LAST	2. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2. HOUR
		Scott L. Smith					7		7	26	1987	10:15
1. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2. DATE PRONOUNCED DEAD		2. HOUR
Male	White	1 22 15		72 YRS.						7 26 1987		10:15
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.		WIDOWED		DIVORCED		Baltimore City,		MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		1803 Wilhelm St.				Retired		Railroad				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1803 Wilhelm St.		21223		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS				
Scott L. Smith, Sr.		Gertrude Bosley		215-12-4010		Gertrude Metcalf		117 S. Payson St.		Baltimore, Md. 21223		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS		17. ADDRESS				
Yes		W.W.II		215-12-4010		Gertrude Metcalf		117 S. Payson St.		Baltimore, Md. 21223		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Carcinoma of Bladder</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		M.D.		Assistant		7-27-87		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto. Md.		21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		7/29/87		Baltimore National		Baltimore				Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Harry H. Witzke		4112 Columbia Rd.		JUL 31 1987		J. H. Witzke						
Ellicott City, Maryland												

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20140

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas Smith			2a. DATE OF DEATH MONTH DAY YEAR 7 25 87		2b. HOUR 3:55 P.M.						
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 4 27		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Disabled.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 400 W. Franklin St. 21201			
14. FATHER'S NAME FIRST MIDDLE LAST Roy Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa L. Cohen								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 251-20-7733			17. INFORMANT James B. Smith			ADDRESS 15622 Emery Ct.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gram negative sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9 July</u> , 19 <u>87</u> , to <u>25 July</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>25 July</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lea Starn MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 7/25/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STERN						22e. ADDRESS 4940 Eastern Ave Baltimore Md 21224					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/1/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue						25a. DATE REC'D. BY REGISTRAR JUL 31 1987			25b. REGISTRAR'S SIGNATURE		

BP

061882 AUG-281

FOR GOLDEN-EPH
THE NEW
CONV

JUL 31 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG NO

1. DECEASED NAME (PRINT) FIRST MIDDLE LAST Zeno Smith			2a. DATE OF DEATH MONTH DAY YEAR 7/23/87		2b. HOUR 4:14 AM	
3. SEX M		4. RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR 12 01 19		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.	
14. FATHER'S NAME FIRST MIDDLE LAST Fletcher Smith			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche LEE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 238-28-7244		17. INFORMANT Mrs. Dannie Smith		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Lung ca E mets. (to brain)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (IF NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/19, 19 87, to 7/23, 19 87, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (and not) view the body after death.						
22b. SIGNATURE R. Shetney		DEGREE MD		22c. DATE SIGNED 7/23/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/28/87		23c. NAME OF CEMETERY OR CREMATORY BALTO. Cemetery		
24. FUNERAL DIRECTOR NAME March Funeral Home		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 28 1987		
25b. REGISTRAR'S SIGNATURE John Davidson-Rodgers						

BP

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091510 JUL 30 91

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060550 JUL 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20142

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NAMIKO A. SNOW		2a. DATE OF DEATH MONTH DAY YEAR JULY 19TH, 1987		2b. HOUR P 6:31 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 16, 1947	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Japan		7b. CITIZEN OF WHAT COUNTRY? Japan		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Falls Church	
14. FATHER'S NAME FIRST MIDDLE LAST Norio Arima		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tamiko Tsumagari		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-68-8134		17. INFORMANT ADDRESS 2120 Great Falls Street Falls Church, VA 22043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOW CARDIAC OUTPUT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 HOURS	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RIGHT VENTRICULAR FAILURE				8 HOURS	
DUE TO, OR AS A CONSEQUENCE OF (c) BRONCHITIS OBLITERANS				6 MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: MULTIPLE LUNG INFECTIONS, IMMUNOSUPPRESSION, ANEMIA					
19a. DATE OF OPERATION 7/19/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BRONCHITIS OBLITERANS		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 05-16- 19 87 to 07-19- 19 87 that (I) (we) last saw the deceased alive on 7/19 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R.S. Finney, MD				22c. DATE SIGNED 7/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.S. FINNEY		22e. ADDRESS JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 07/21/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Colonial Funeral Home 6161 Leesburg Pike Falls Church, VA 22044				25a. DATE REC'D. BY REGISTRAR JUL 22 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The low-qualified information must be entered within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit, Maryland's "page 3" carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of such.
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 DHMH - 16 60M 7/84
 (VRA 15, 4)

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JUL 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

20143

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BELLE SODDEN			2a. DATE OF DEATH MONTH DAY YEAR JULY 22, 1987		2b. HOUR 12:15 M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR Aug. 25 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS	12b. KIND OF BUSINESS OR INDUSTRY CLOTHING	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST SIMON SODDEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-03-5672		17. INFORMANT ADDRESS BERNARD DAVIS 8201 MAXINE CIR (21208)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardioresp arrest DUE TO, OR AS A CONSEQUENCE OF* Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain tumor DUE TO, OR AS A CONSEQUENCE OF (c) Ascuro					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (his hospital) attended the deceased from 7-19-87 , to present 19 87 , that (I) (we) last saw the deceased alive on 7-19-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE S. D. Binesh, M.D.				22c. DATE SIGNED 7/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. D. Binesh, M.D.				22e. ADDRESS 11 Slack Ave.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/23/87	23c. NAME OF CEMETERY OR CREMATORY Mikro Kadesh Beth Israel - Baltimore, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.			25a. DATE REC'D. BY REGISTRAR JUL 24 1987		
6010 REISTERSTOWN RD. BALTIMORE, MD 21215			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. When please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified by page 4.

BP

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061497 AUG 4 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

20144

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Isaiah Solomon Sr.			2a. DATE OF DEATH MONTH DAY YEAR 7/28/87			2b. HOUR MIN. 5⁴ AM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 25 34		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 52	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD	
10. CITY OR TOWN OF DEATH Baltimore City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	
12b. KIND OF BUSINESS OR INDUSTRY Allied Bendix		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1345 Homestead St. 21218		14. FATHER'S NAME FIRST MIDDLE LAST King David Solomon		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Silver	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. Blanche Solomon Rt. 2 Box 10A, Halifax, N.C.		17. INFORMANT ADDRESS Blanche Solomon Rt. 2 Box 10A, Halifax, N.C.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? Hemorrhage - MI ? DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Ca - esophagus							
19a. DATE OF OPERATION 7/27/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca - distal 2nd/3rd esophagus		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED 7/28/87	
22b. SIGNATURE [Signature]				22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) S A MENZIES	
22e. ADDRESS V.M.H				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23b. DATE 8/1/87		23c. NAME OF CEMETERY OR CREMATORY Allen Grove Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Halifax N.C.		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.	
25a. DATE REC'D. BY REGISTRAR JUL 31 1987				25b. REGISTRAR'S SIGNATURE [Signature]			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

001431 AUG-14-83

RECEIVED

JUL 21 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) CHESTER S. SOMERS					2a. DATE OF DEATH MONTH DAY YEAR 07 5 87					2b. HOUR 8:20A	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 04 15			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND USA		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GEN. HOSP					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder			12b. KIND OF BUSINESS OR INDUSTRY Metal	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN BROOKLYN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 107 WALLACE AVE (21225)			
14. FATHER'S NAME FIRST MIDDLE LAST CAZMER GR YGLEWSKI				15. MOTHER'S MAIDEN NAME FIRST LAST CARRIE SOMERS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217051807		17. INFORMANT ADDRESS Mary Somers - same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Adenocarcinoma lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/16 , 19 87 , to 7/5 , 19 87 , that (I) (we) last saw the deceased alive on 7/5 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Prafull Patel						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/5/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PRAFULL PATEL						22e. ADDRESS 3001 S. HANOVER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-8-87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk., A.A. Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce, 4001 Ritchie Hwy., Baltimore											
25a. DATE REC'D. BY REGISTRAR JUL 07 1987						25b. REGISTRAR'S SIGNATURE Julia Swinson-Rudolph					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the detached page to the Division of Vital Records, Department of Health and Mental Hygiene, 201 W. Preston St., Baltimore, Maryland 21201.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SELMA D. SPEAR		20. DATE OF DEATH MONTH DAY YEAR JULY 14, 1987		21. HOUR 8:35 AM					
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 7, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Frederich Deichmiller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Koch		13e. STREET ADDRESS / ZIP CODE 3740 Old York Rd., 21218					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214 30 2907		17. INFORMANT ADDRESS Shirley L. Adams, Balto. Co., MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cholangitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>sepsis ; renal colic ; brain damage</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION 06/27/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED exploratory laparotomy & removal of stone		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (if this hospital) attended the deceased from <u>6/24/87</u> , 19 <u>87</u> , to <u>7/14</u> , 19 <u>87</u> , that (if not) last saw the deceased alive on <u>7/14</u> , 19 <u>87</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (b) (c) (d) (did not) view the body after death.							
22b. SIGNATURE Jarek Sojnowski		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 07.14.87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jarek Sojnowski		22e. ADDRESS Tenion Towentam Blvd 21204 MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/17/87		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery					
23d. LOCATION CITY OR TOWN COUNTY STATE Cecil County, MD		25a. DATE REC'D. BY REGISTRAR JUL 16 1987							
24. FUNERAL DIRECTOR NAME H. W. Jenkins,		ADDRESS 21212		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP

020830 JUL 12 81

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8 REG. NO. 2014
DATE OF DEATH MONTH DAY YEAR 07 04 87 7:02

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		87 REG. NO. 20147	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR	
ANDREA SPEARS				07 04 87 7:02 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR 8. IF UNDER 24 HRS.	
Female	Black	8 MONTH 6 DAY 66	20	MONTHS DAYS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Church Home Hospital		Unemployed		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. CITY OR TOWN		13b. STREET ADDRESS / ZIP CODE	
13a. STATE 13b. COUNTY		Baltimore		21202	
Md.				26 S. Exter St. Apt. 5G	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.	
Joseph Spears		Rose Marie Woods		214-84-6803	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214-84-6803		Rosemarie Woods 1138 E. Fayette St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) HEPATIC COMA					
DUE TO, OR AS A CONSEQUENCE OF (b) FILLMINANT HEPATITIS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 07/03 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE V.M. Abhyanzar MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22c. DATE SIGNED	
V.M. ABHYANZAR, M.D.		CHURCH HOSPITAL 100N. BROADWAY, BALTIMORE, MD. 21231			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		7-10-87		Eastview Cemetery	
24. FUNERAL DIRECTOR NAME		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
March Funeral Home		JUL 10 1987		Jana B. Jones	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Eastview Cemetery		Baltimore Md.			

RECEIVED
JUL 10 1961

JUL 10 1961

059703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20148
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERTIE LEE SPEARS			2a. DATE OF DEATH MONTH DAY YEAR 07 12 87		2b. HOUR 07:20 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 02 06 1926		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD		
13a. STATE MD			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 910 Lynhurst St 21229			
14. FATHER'S NAME FIRST MIDDLE LAST Jerry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie M. Robinson		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-24-3445		17. INFORMANT ADDRESS Elmer R. Spears 910 Lynhurst Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC ADENOCARCINOMA OF LIVER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PRIMARY CARCINOMA OF GALL BLADDER</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 11</u> , 19 <u>87</u> , to <u>JULY 12</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>JULY 12</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u> MD				22c. DATE SIGNED 7-12-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BOON P. LIM, MD				22e. ADDRESS ST. AGNES HOSPITAL 900 CATON AVE BALT MD 21229		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/17/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR JUL 14 1987		
25b. SIGNATURE <u>[Signature]</u>		25c. SIGNATURE <u>[Signature]</u>				

100-100

ADDITIONAL PAGES
PHOTOGRAPH

100-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20149
REG. NO.

1 - FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Raymond		Speed		2 13 05		82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Va.		USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		5685 Purdue Ave. # B-3		Serviceman		US Army	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
George		Annie		Yes		1943-1965	
17. INFORMANT		18. ADDRESS		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Margaret M. Ryan		4807 Valley Forge Rd.					
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>probable myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. INJURY OCCURRED		21b. PLACE OF INJURY	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION		21e. DATE OF OPERATION		21f. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		STREET CITY OR TOWN COUNTY STATE		19 87		19 87	
22a. I certify that (1) (this hospital) attended the deceased from <u>spring</u> 19 <u>87</u> , to <u>July 21</u> 19 <u>87</u> , that (1) (we) lost <u>saw the deceased alive or above (below) (did not view the body after death)</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Victoria A. Vanik MD		7/24/87		Victoria A. VANIK		Brehms Lane Medical Center	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		7/25/87		Stevenson AME C. Cem		SPARKS Balto. Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
Chatman-Harris FH 1701 McCulloh Street		JUL 27 1987					

MEDICAL CERTIFICATION

061020 JUL 59 81

059199 JUL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

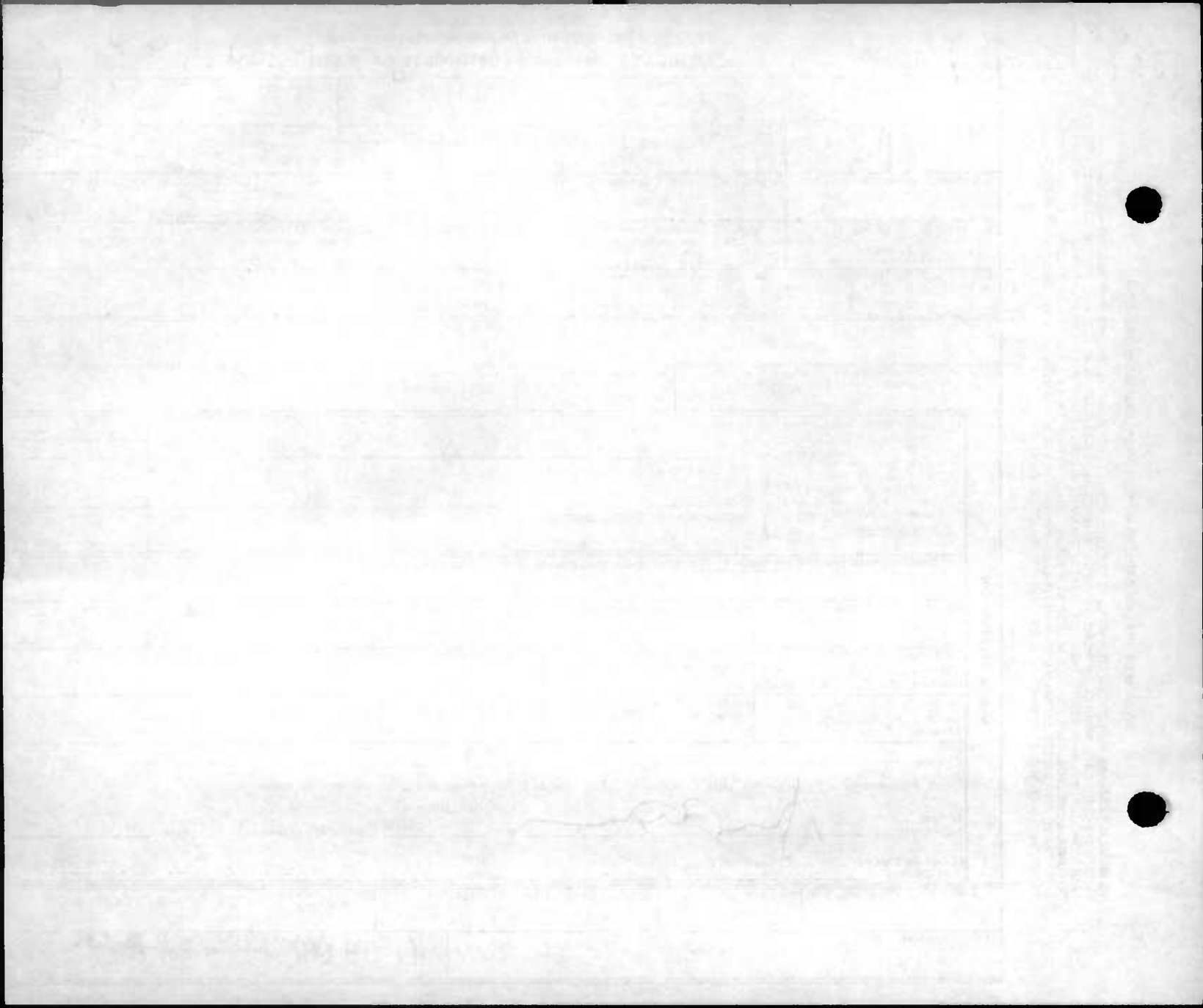
20150

1- STATE REGISTRAR		FOR		STATE		REGISTRAR		REC. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH	
LILLIAN		SPENCE		DATE KNOWN OF DEATH		MONTH		DAY	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.	
F		B		12 22 26		60 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		2c. DATE PRONOUNCED DEAD	
RICHMOND, VA.		U.S.A.		WIDOWED		DIVORCED		7 7 1987	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		7d. HOUR	
Baltimore		1300 E. Lanvale St.		AVON REP.		AVON		5:05	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.		BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1300 E. LANVALE ST.		21213	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
EDWARD		LILLIE		NO		217-20-0534		BRIGGS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Hypertensive cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(b)					
				(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY	
21g. LOCATION		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion	
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>	
Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		7/7/87			
EXAMINER'S NAME (TYPE OR PRINT)		Ann M. Dixon, M.D.		ADDRESS		111 Penn Street, Balto. Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY	
REMOVAL		7-7-87				CITY OR TOWN		STATE	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
STATE ANATOMY BOARD						JUL 08 1987		John A. Dixon	

07/84
25M

BP

DHMH - 17
(VR A15 ME (1))



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO. 20151

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN G. SPENCER			2a. DATE OF DEATH MONTH DAY YEAR JULY 5, 1987		2b. HOUR 7:30 P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 31, 1913		
6. AGE (IN YEARS (LAST BIRTHDAY)) 73		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		MD.				
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER			12b. KIND OF BUSINESS OR INDUSTRY HOME			

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2005 CLIFDEN ROAD 21228	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID H. SPENCER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA V. (UNKNOWN)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-30-4055			17. INFORMANT ADDRESS MRS. EVELYN THIELE 2005 CLIFDEN ROAD CATONSVILLE, MD. 21228				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCT</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1ST DEGREE HEART BLOCK</u>		<u>3 yrs</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>A S C V D</u>		<u>3 yrs</u>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>1984</u> , to <u>JULY 5</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>JULY 2</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Norman R. Kleiman</u> MD						22c. DATE SIGNED <u>6/6/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN R. KLEIMAN M.D.						22e. ADDRESS 3803 EDMONDSON AVENUE, BALTIMORE, MD. 21229	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/8/87		23c. NAME OF CEMETERY OR CREMATORY DEER PARK		23d. LOCATION CITY OR TOWN COUNTY STATE WESTMINSTER MARYLAND	
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOEMS P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228						25a. DATE REC'D. BY REGISTRAR JUL 7 1987	
						25b. REGISTRAR'S SIGNATURE <u>Julia Davis</u>	

028832

JOY FIELD
DOWD

July 1884

059845 JUL 17 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/1
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1- STATE
REGISTRAR

87 REG. NO. 20152

DECEASED NAME (TYPE OR PRINT) Margaret Spiros.		2a. DATE OF DEATH MONTH DAY YEAR 7 14 87		2b. HOUR 4:45 PM
3. SEX FEMALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 14 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH 84 City MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 504 S. Newkirk Street	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY -	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 504 S. Newkirk Street 21224
14. FATHER'S NAME FIRST MIDDLE LAST George Mavris		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emelia Savas		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 232-07-1878D		17. INFORMANT George Pappas, 2215 Springlake Drive Timonium, Md. 21093
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy with congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr x years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NIGHT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/14/87 to 7/14/87, that (I) (we) last saw the deceased alive on 7/14/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)				
22b. SIGNATURE Patricia Jay Coon MD		DEGREE MD		22c. DATE SIGNED 7/14/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia Jay Coon MD		22e. ADDRESS 4940 Eastern Ave, Balto, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-17-87	23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR Ann S. Matthews, Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224		25a. DATE REC'D BY REGISTRAR JUL 16 1987		
		25b. REGISTRAR'S SIGNATURE Julia Bender-Landau		

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020842 JUL 17 67

X

060401 JUL 23 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC'D NO. 0153

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	7a. DATE KNOWN OF DEATH		8. MONTH	9. DAY	10. YEAR	11. HOUR
Louis G. Spittel					7a. DATE KNOWN OF DEATH		8. MONTH	9. DAY	10. YEAR	11. HOUR
12. SEX	13. RACE	14. DATE OF BIRTH	15. AGE (IN YEARS)	16. IF UNDER 1 YR.	17. IF UNDER 24 HRS.	18. DATE PRONOUNCED DEAD	19. MONTH	20. DAY	21. YEAR	22. HOUR
Male	White	June 28 14	73 YRS.			7	19	87		11:50
13a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		13b. CITIZEN OF WHAT COUNTRY?		14. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		15. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA				Baltimore City, MD.				
16. CITY OR TOWN OF DEATH		17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				18. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		19. KIND OF BUSINESS OR INDUSTRY		
Baltimore		St. Agnes Hospital				Engineer		Koppers & Co.		
20. STATE	21. COUNTY	22. CITY OR TOWN	23. INSIDE CITY LIMITS?	24. STREET ADDRESS						
Maryland	Baltimore	Arbutus	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	5506 Rockleigh Drive 21227						
25. FATHER'S NAME			26. MOTHER'S MAIDEN NAME							
George L. Spittel, Sr.			Anna Beck							
27. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		28. SOCIAL SECURITY NO		29. INFORMANT		30. ADDRESS				
Yes		WW II		216-03-0052		Charles H. Spittel, 3850 Spencer Court				
31. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <u>Diabetes mellitus</u>										
33a. DATE OF OPERATION		33b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				34. AUTOPSY?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
35a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		35b. TIME OF INJURY		35c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
		P.M. 19								
36a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		36b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		36c. LOCATION						
				STREET CITY OR TOWN COUNTY STATE						
37. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
38. ACTUAL SIGNATURE		39. TITLE (SPECIFY)		40. DATE SIGNED						
<i>Margarita A. Korell</i>		M.D. Assistant MEDICAL EXAMINER		7-20-87						
41. EXAMINER'S NAME (TYPE OR PRINT)		42. ADDRESS								
Margarita A. Korell, M.D.		111 Penn St., Balto. Md. 21201								
43a. BURIAL, CREMATION, REMOVAL (SPECIFY)	43b. DATE	43c. NAME OF CEMETERY OR CREMATORY		43d. LOCATION		44. COUNTY STATE				
Burial	7/22/87	Lorraine Park Cemetery		Woodlawn		Baltimore Md.				
45. FUNERAL DIRECTOR NAME		46. ADDRESS		47. DATE REC'D. BY REGISTRAR		48. REGISTRAR'S SIGNATURE				
Hubbard Funeral Home, Inc.,		4107 Wilkens Ave.		JUL 22 1987		<i>Julia Darden-Randall</i>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

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30% COTTON UBBB

WIND

WIND



100% COTTON

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20154

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH EST. MATED			MONTH	DAY	YEAR	2b. HOUR
Jerzy					Stachowski	7			12	1987		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
MALE	CAUC.	12-02-44	42 YRS.			7			12	1987	12:45	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
POLAND			USA						Baltimore City, MD.			
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore			1800 Blk. Fleet Street			SANDBLASTER			Buffalo, TN			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS			
MARYLAND						BALTIMORE			3127 Elliott St. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
FLORIAN			STACHOWSKI			ANNA			ZMINKOWSKI			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO			078-62-7868			MRS HELEN STACHOWSKI			SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
			12:40xx 7 12 1987			Pedestrian struck by auto(s)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
			street			1800 Blk. Fleet St, balto.			MD			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accidents <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED						
Carles P. Kokes, M.D.			Assistant			7/12/87						
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			BALTO, MD						
Carles P. Kokes, M.D.			111 Penn St.			Balto, MD						
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL			7.15.87			St. Stanislaus Cem			BALTIMORE MD			
24. FUNERAL DIRECTOR NAME ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
KACZOROWSKI F. HOME			2555 Fleet St.			JUL 14 1987			Julia Davidson			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 15 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESIDENT ST., BALTIMORE, MD, 21201

07/84
25M

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DHMH - 17
(VR A15 ME (5))

060372 JUL 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20155

1. DECEASED NAME (TYPE OR PRINT) Xavier Daniel Stachura, Sr.			2a. DATE OF DEATH MONTH DAY YEAR July 18, 1987		2b. HOUR 3:40 P.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 13, 1945		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Director Data Proc.		12b. KIND OF BUSINESS OR INDUSTRY Hospital
13a. STATE Maryland	13b. COUNTY A A Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 116 Linwood Avenue 21061	
14. FATHER'S NAME FIRST MIDDLE LAST John Stachura		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Chachulski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) NA	17. INFORMANT (Wife) Doris M. Stachura		ADDRESS Same As #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: - IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADENOCARCINOMA OF THE LUNG</u> 7 weeks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>6/23</u> , 19 <u>87</u> , to <u>7/18</u> , 19 <u>87</u> , that (we) last saw the deceased alive on <u>7/18</u> , 19 <u>87</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>				22c. DATE SIGNED 7/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FERNANDO J. FERNANDEZ				22e. ADDRESS ST. AGNES HOSPITAL 900 CATON AVE BALTIMORE, MD 21229	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 22, 1987	23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery Dundalk		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME <i>[Signature]</i> Singleton Funeral Home Glen Burnie, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 21 1987	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

35 40 35 20 2

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

EX-100-111111

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EX-100-111111

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061642 AUG -4 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 20156

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard Edward Stacy			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7/ 29/ 1987		2b. HOUR 1:15 P M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Nov 10, 1941	6. AGE (IN YEARS) (LAST BIRTHDAY) 45 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Massachusetts		12b. COUNTY Hampden Co.		12c. CITY OR TOWN Springfield	
13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 140 Chestnut Street 99999			
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Stacy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhemina Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		16b. SOCIAL SECURITY NO. 049-30-7070		17. INFORMANT Ernest Stacy (Bro)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Stab Wounds with Complications DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:56xx 7/ 5/ 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) on street		21f. LOCATION CITY OR TOWN COUNTY STATE 1800 Blk. Hargrove St., Balto. City, Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) Assistant MEDICAL EXAMINER		DATE SIGNED 7/30/87	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 4, 1987		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Park	
23d. LOCATION CITY OR TOWN Springfield, Mass.		STATE			
24. FUNERAL DIRECTOR NAME Capitol Funeral Service		ADDRESS Falls Church, Virginia		25a. DATE REC'D. BY REGISTRAR AUG 3 1987	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
BP
DHMH / 17
(VR A15 ME (5))

060266

JUL 22 1987

FOR
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20157
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Williams Henry Stamper Sr.			2a. DATE OF DEATH MONTH DAY YEAR July 15, 1987		2b. HOUR M M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR June 25, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2569 W. Lombard St. 21223	
14. FATHER'S NAME FIRST MIDDLE LAST James Stamper		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellis Stamper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-10-1741		17. INFORMANT ADDRESS Willettta Robinson 2557 W. Lombard St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Septic Shock DUE TO, OR AS A CONSEQUENCE OF (b) ② Adult Respiratory distress Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) ③ Status epilepticus					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/15/86 to 7/15/87 that (I) (we) last saw the deceased alive on 8/15/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE		22c. DATE SIGNED 7/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCELINO D. ALBUERNE, M.D.		22e. ADDRESS 5772 WESTVIEW MALL BALT. MD. 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/18/87	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, B.C. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Charles A. Rice FSPA 1300 Eutaw Place		25a. DATE REC'D. BY REGISTRAR JUL 21 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page is to be removed from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Page 3 is to be retained by the funeral director.

000500 70 55 01

RECEIVED

MAILED



FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20158

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bella Steiner		2a. DATE OF DEATH MONTH DAY YEAR July 31, 1987		2b. HOUR 1:55 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 3, 1900	
6. AGE (IN YEARS LAST BIRTHDAY) 86		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY AT HOME		13a. STATE MARYLAND		13b. COUNTY BALTO.	
13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS - ZIP CODE 3601 CLIFMAR RD. #21207	
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN GROSS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE PROPER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 214-38-6887		17. INFORMANT DR. JEROME STEINER		ADDRESS 3601 CLIFMAR RD. BALTO., MD 21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Abdomen DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Edwin B. George MD, PhD		DEGREE MD, PhD		22c. DATE SIGNED 7/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin B. George		22e. ADDRESS Sinai Hosp of Balt.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE AUG. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW	
23d. LOCATION REISTERSTOWN BALTO.		MD.		24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215	
25a. DATE RECEIVED BY REGISTRAR AUG 5 1987		25b. REGISTRAR'S SIGNATURE Jane Barber-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial, cremation, or removal.

0508 WNE-805

0508 WNE-805

060789

JUL 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20159

1. DECEASED NAME (LAST OR FIRST) Lois Wanda Stemple		2a. DATE OF DEATH MONTH DAY YEAR 7 22 87		2b. HOUR 4:15 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 26, 1932	
6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Corner Stable	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center		13a. STREET ADDRESS / ZIP CODE 4317 Ridge Rd. 21236	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Fullerton	
14. FATHER'S NAME FIRST MIDDLE LAST William Hibbert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva McLaughlin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 219-28-2086		17. INFORMANT Mr. Mark W. Stemple		ADDRESS Pikesville, MD 21208 17 Dreher Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF: (b) Infection Source Unknown DUE TO, OR AS A CONSEQUENCE OF: (c) Anoxic Encephalopathy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 22 hrs 3 months 2 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic Obstructive Pulmon. Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. B. Greenough Jr		DEGREE MD		22c. DATE SIGNED 7-22-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. B. Greenough Jr		22e. ADDRESS Francis Scott Key Medical Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7-23-87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore MD		24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc 8728 Liberty Rd. Randallstown, MD 21133			
25a. DATE REC'D. BY REGISTRAR JUL 24 1987		25b. REGISTRAR'S SIGNATURE <i>John P. ...</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon duplicate pages. This form should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

080188 JUL 27 81

REBIL MOTION NO2

WALTON

JUL 28 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be marked by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

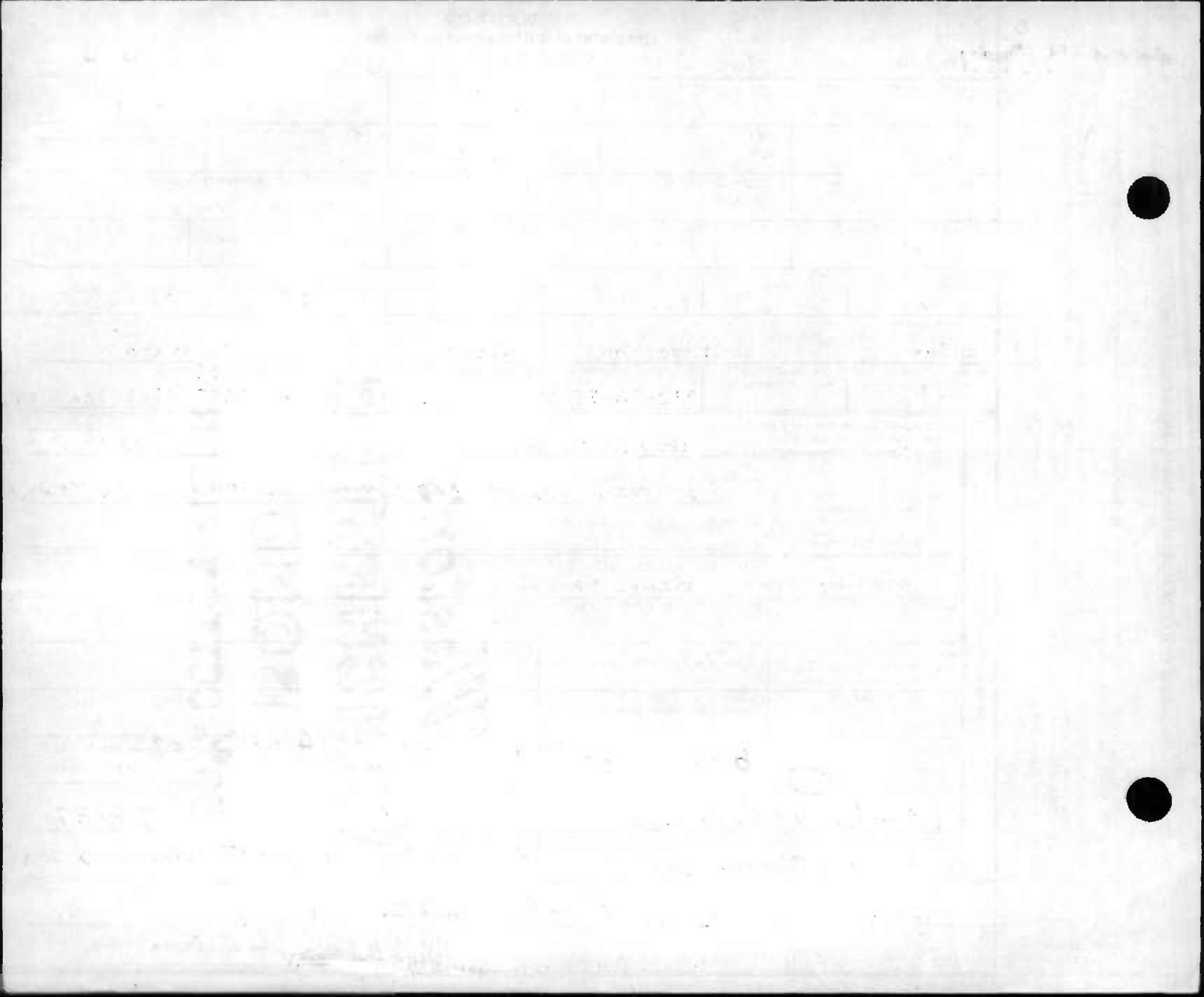
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial or cremation.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20160

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLIE STEVENSON			2a. DATE OF DEATH MONTH DAY YEAR 7 5 87		2b. HOUR M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1 6 28		6. AGE (IN YEARS (LAST BIRTHDAY)) 59 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Fairfield	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3423 Fieldlea Ct.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Fairfield	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Rufus Stevenson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Woodward		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. 212-24-7586	17. INFORMANT ADDRESS 21226 Rosa L. Stevenson 3423 Fieldlea Ct.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 10 YEARS DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a EMPHYSEMA, RENAL FAILURE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 6/30, 1987, to 7/4/87, 1987, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. CHINTRISMA MD.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. CHINTRISMA MD.		22e. ADDRESS 827 UNDER AVE., BALTIMORE, MD. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-10-87	23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H		ADDRESS 1101 E. North Ave.		25a. DATE RECEIVED BY REGISTRAR JUL 14 1987	



060178 JUL 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of and

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) MILTON P. STIVERS					2a. DATE OF DEATH MONTH DAY YEAR 7 17 1987					2b. HOUR 10:15 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 7/22/13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD			12b. KIND OF BUSINESS OR INDUSTRY Electrician Western Elec.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b. KIND OF BUSINESS OR INDUSTRY Western Elec.		
13a. STATE Md.			13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4909 Wright Ave, 21205		
14. FATHER'S NAME FIRST MIDDLE LAST Elnathan Stivers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Arlene Lacy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --		17. INFORMANT Noel T. Stivers, Son, 3812 Overlea Ave,		ADDRESS 21206					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart failure + pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 15</u> , 19 <u>87</u> , to <u>July 17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>July 17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>S. Abu Jawdeh</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SALIM ABOU JAOUOE						22e. ADDRESS THE GOOD SAMARITAN HOSP					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/20/87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith			23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.			
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, Balto, Md. 21213						25a. DATE REC'D. BY REGISTRAR JUL 20 1987			25b. REGISTRAR'S SIGNATURE <u>John A. Jones</u>		

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JUL 25 81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. 29162

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRENE E. STOKES			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 7-25-87		2b. HOUR M 8:04P
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 4 24 19	6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7-25-87
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2122 N. Wolfe Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	
13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.	
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT W. STOKES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIE SULLIVAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-12-1969A		17. INFORMANT ADDRESS LILLIE STOKES 2122 N WOLFE ST.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 7-29-87

EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/29/87	23c. NAME OF CEMETERY OR CREMATORY MD NAT'L MEM. PARK	23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL MD
24. FUNERAL DIRECTOR NAME ADDRESS WM. C. MARCH F/H 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUL 29 1987 Julia Benson-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR ITEM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20163

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE Anthony STOLZE			2a. DATE OF DEATH MONTH DAY YEAR July 2, 1987			2b. HOUR 7¹⁵ PM					
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Jan. 3, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector (Ret)		12b KIND OF BUSINESS OR INDUSTRY Civil Service			
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Catonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 711 Maiden Choice Lane Apt 1405 21228			
14. FATHER'S NAME FIRST MIDDLE LAST Henry J. Stolze			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah L. Wickham			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No NA					
16b SOCIAL SECURITY NO. 216.44.6670			17 INFORMANT (Daughter) Doris J. Collier			ADDRESS 4081 Water View Dr. Edgewater, Md. 21037					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electromechanical Asphyxiation								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minute			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b) Probable pulmonary embolism		2 hours	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (his hospital) attended the deceased from Feb 19 87 to July 2 19 87 . That (1) (we) last saw the deceased alive on 7-2-87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
23a SIGNATURE William M Russell MD						DEGREE MD		22c DATE SIGNED 7-2-87			
23b PHYSICIAN'S NAME (TYPE OR PRINT) William M Russell						22e ADDRESS St Agnes Hospital.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE July 6, 1987		23c NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A A Co. Md.				
24 FUNERAL DIRECTOR NAME R. A. Hopkins						25a DATE REC'D. BY REGISTRAR July 7 1987		25b REGISTRAR'S SIGNATURE Julia Terison-Randall			
ADDRESS Singleton Funeral Home Glen Burnie, Maryland											

WATERLOO, N.Y.
JAN 10 1901

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours very truly,
J. H. Rogers

060669

JUL 24-87

OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

20164

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILBUR O. STONE			2a. DATE OF DEATH MONTH DAY YEAR 7/14/87		2b. HOUR 4:35 A.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 18 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER	12b. KIND OF BUSINESS OR INDUSTRY CONTINENTAL CAN	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN ESSEX	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1 EASTERN AVE. 21221
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-03-3823	17. INFORMANT ADDRESS PATRICIA GOSMAN 1217 JARRETTSVILLE FORESTHILL MD. 21050		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COPD & Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Urinary tract infection DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/18/87 to 7/14/87, that (I) (we) last saw the deceased alive on 7/14/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE A.C. Chouvalit, M.D.		DEGREE M.D.		22c. DATE SIGNED 7/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. CHOUVALIT, M.D.		22e. ADDRESS NORTH CHARLES GEN. HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7-18-87	23c. NAME OF CEMETERY OR CREMATORY BELAIR MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE BELAIR HARBOR MARYLAND	
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES		ADDRESS 8800 HARBOR RD. PARKVILLE 21234		25a. DATE REC'D. BY REGISTRAR JUL 23 1987	25b. REGISTRAR'S SIGNATURE Julia J. [Signature]

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed with #72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called along.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place over the carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

REG. NO. 0163

1. DECEASED NAME (TYPE OR PRINT) EVELYN M. STORCK		20. DATE OF DEATH MONTH DAY YEAR 07/02/1987		2b. HOUR 7:37 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 08/19/1920	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOOD SAMARITAN HOSP.		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASS. LINE		12b. KIND OF BUSINESS OR INDUSTRY ELECTRONIC		13a. STREET ADDRESS / ZIP CODE 7705 Wilson Ave 21234	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST Winfred PEREGOY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie V. GRONFOW		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 218073514		17. INFORMANT FAMILY RECORDS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 minutes 11 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (if (this hospital) attended the deceased from 06/20/1987 to 07/02/1987 , that (he) (she) (it) (we) (they) (did) (did not) view the body after death.					
22a. SIGNATURE F. KHAWLI				22c. DATE SIGNED 07/02/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. KHAWLI				22e. ADDRESS GOOD SAMARITAN HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-6-1987		23c. NAME OF CEMETERY OR CREMATORY LORRAINE PARK	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPEL OF MEMORIES HARFORD		25a. DATE REC'D. BY REGISTRAR JUL 10 1987	
25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) DONATA INGRID STRASSNER					2a. DATE OF DEATH MONTH DAY YEAR JULY 03, 1987					2b. HOUR 12:45 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 23, 1938			6. AGE (IN YEARS LAST BIRTHDAY) 49		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1034 PINE HEIGHTS AVENUE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY			12b. KIND OF BUSINESS OR INDUSTRY HEALTH CARE		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1034 PINE HEIGHTS AVE 21229		
14. FATHER'S NAME FIRST MIDDLE LAST ALFRED CYMER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELAIDE KITTEL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-36-5639		17. INFORMANT ADDRESS LELAND J. STRASSNER, JR. 1034 PINE HEIGHTS AVE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>LYMPHOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 1</u> , 19 <u>87</u> , to <u>JULY 3</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>JULY 1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Mitchell A. Kaminski, M.D.</u>					DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MITCHELL KAMINSKI					22e. ADDRESS 7411 PINKWOOD COLUMBIA, MARYLAND 21046						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 07/04/87		23c. NAME OF CEMETERY OR CREMATORY BALTO.-WASH. CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE LAUREL P.G. MARYLAND			
24. FUNERAL DIRECTOR NAME AMBROSE FUNERAL HOME					25a. DATE REC'D. BY REGISTRAR JUL 6 1987			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20161
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mary C Strickland			2a. DATE OF DEATH MONTH DAY YEAR 07 04 87			2b. HOUR 10:05 P.M.					
3. SEX F Female		4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR 11 13 08		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt City MD.					
10. CITY OR TOWN OF DEATH Balt. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med Ctr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nursing Ass't.		12b. KIND OF BUSINESS OR INDUSTRY St. Joseph Hosp.			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7865 St. Bridget Lane 21222		
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Dorsey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Moriah Clark			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214-24-5806	
17. INFORMANT Joan Strickland			ADDRESS 7865 St. Bridget Lane 21222			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Urinary tract infection DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22a. SIGNATURE Paul T. Diamond						DEGREE MD		22c. DATE SIGNED 07-04-87		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul T. Diamond						22e. ADDRESS Francis Scott Key Med Ctr.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-8-87		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		25a. DATE REC'D. BY REGISTRAR JUL 08 1987		
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk			ADDRESS 7922 Wise Ave. Dundalk, MD 21222			25b. REGISTRAR'S SIGNATURE [Signature]			25c. REGISTRAR'S SIGNATURE [Signature]		

20% COTTON FIBER

FEATHER

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 18. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

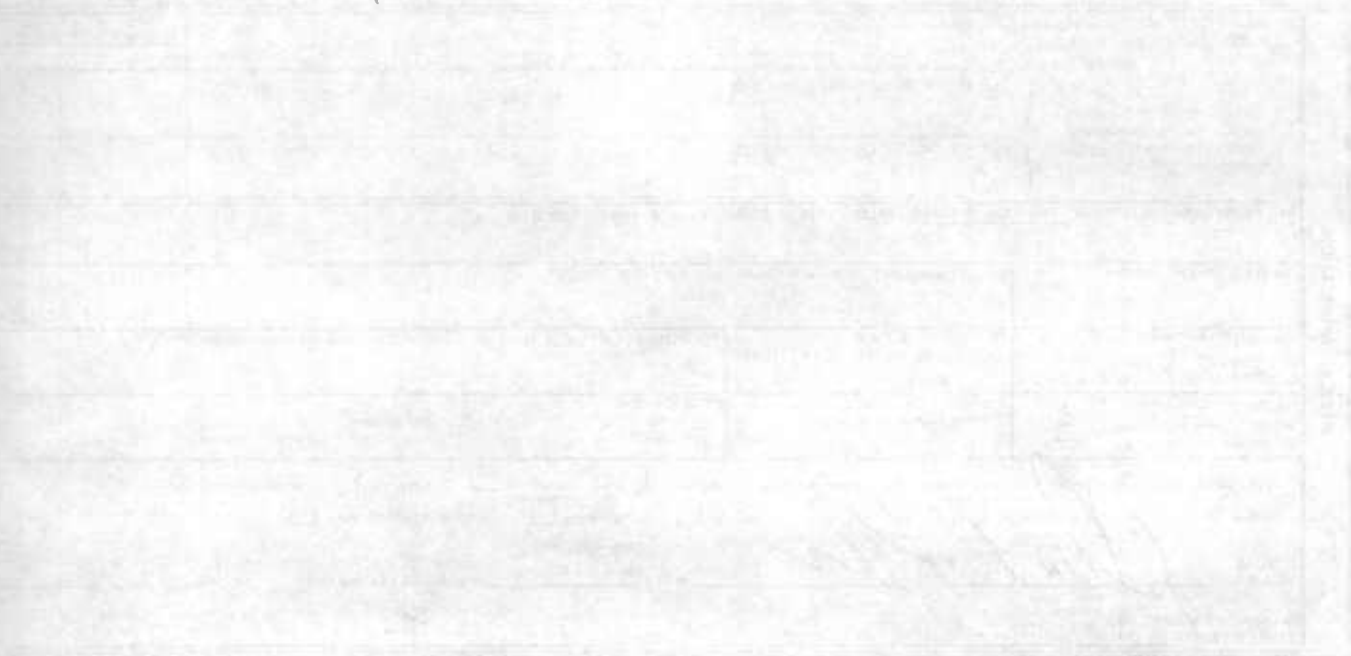
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME FIRST MIDDLE LAST Charles Stringos												2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7 9 1987	2b. HOUR M 8:30 P.M.
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Oct. 12, 1919	6 AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 9 1987	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chauffeur			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Ctr.				12a. USUAL RESIDENCE (IF INHABITING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Mass. 13b. COUNTY Middlesex 13c. CITY OR TOWN Somerville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 74 Washington St. 02143				
14. FATHER'S NAME FIRST MIDDLE LAST George Stringos				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olga Kargianis				17. INFORMANT Somerville, Mass. 02143 Orania Stringos, 74 Washington St.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <i>Charles P. Kokes</i>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 7-10-87					
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.				ADDRESS 111 Penn St., Balto. Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 14, 1987				23c. NAME OF CEMETERY OR CREMATORY Greek Orthodox				23d. LOCATION CITY OR TOWN STATE Somerset N.H.	
24. FUNERAL DIRECTOR ROBERT C. ALTENBURG				FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214				25a. DATE REC'D. BY REGISTRAR JUL 13 1987				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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U.S. GOVERNMENT PRINTING OFFICE: 1964 O - 358-100

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION
NORTHWEST REGION
SALT LAKE CITY, UTAH



WATER RESOURCES DIVISION
NORTHWEST REGION
SALT LAKE CITY, UTAH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87		REG. NO. 20169					
2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR					
7-15-87		7-15-87		650 P					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. BALTIMORE CITY OR COUNTY OF DEATH	
male		Black		01 09 17		70 YRS.		Baltimore City MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
S.C.		U.S.A.				Baltimore City			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Francis Scott Key		Retired					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MD				Baltimore				3768 Bonview Ave 21213	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Perry		Strong		No		212-25-0622A		Bessie Lofland 3768 Bonview Ave. 21213	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardio Pulmonary Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		5 mins			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Hepatic Failure, Septic Shock		1 week					
		(c) Severe Periph Vascular Disease		++ years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
Renal Failure									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
7-15-87 0300 am		Gangrenous Foot							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
		19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 10, 19 87, to July 15, 19 87, that (I) (we) last saw the deceased alive on July 15, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
Nancy Chang		M.D.		July 15/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Nancy Chang		Francis Scott Key							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		7-19-87		Armenia Bapt. Ch. Cem.		Chester S.C.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
March Funeral Homes, Inc. 1101 E. North Ave.		JUL 17 1987		Julia Davidson-Randall					

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WHEAT

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DOWN

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20170

REG. NO.

060276 JUL 22 87

FOR
1 - STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) DAISY BELLE STURDIVANT			2a DATE OF DEATH MONTH DAY YEAR 7/20/1987		2b HOUR 3:00 AM
3 SEX F	4 RACE B	5 DATE OF BIRTH MONTH DAY YEAR 4 20 23	6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS		12a USUAL OCCUPATION / (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
13a STATE MD.	13b COUNTY CITY	13c CITY OR TOWN BALTIMORE	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 406 POPLAR GROVE ST. 21223	
14 FATHER'S NAME FIRST MIDDLE LAST William P. LITTLE		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA DEAN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. 239 347588	17 INFORMANT ADDRESS William T LITTLE 1517 CHARLOTTE AVE		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ovarian Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a DATE OF OPERATION 7/15/87		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Ovarian carcinoma		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) this hospital attended the deceased from 7/5 , 19 87 , to 7/20 , 19 87 , that (If <input checked="" type="checkbox"/> saw the deceased alive on 7/20 , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (If <input type="checkbox"/> did not view the body after death.					
22b SIGNATURE J. Edwards		DEGREE MD		22c DATE SIGNED 7/20/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 7/24/87	23c NAME OF CEMETERY OR CREMATORY Garrison Forest		23d LOCATION CITY OR TOWN COUNTY STATE Owings Mills Md.
24 FUNERAL DIRECTOR NAME C. Wainwright		ADDRESS 2700 Edmondson Ave.		25a DATE REC'D. BY REGISTRAR JUL 21 1987	
				25b REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement for the death certificate to be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed, the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This permit requires certain particulars. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to final disposition, burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please make two copies of pages 1 and 2 and 3 and 4 and 5 and 6 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 and 138 and 139 and 140 and 141 and 142 and 143 and 144 and 145 and 146 and 147 and 148 and 149 and 150 and 151 and 152 and 153 and 154 and 155 and 156 and 157 and 158 and 159 and 160 and 161 and 162 and 163 and 164 and 165 and 166 and 167 and 168 and 169 and 170 and 171 and 172 and 173 and 174 and 175 and 176 and 177 and 178 and 179 and 180 and 181 and 182 and 183 and 184 and 185 and 186 and 187 and 188 and 189 and 190 and 191 and 192 and 193 and 194 and 195 and 196 and 197 and 198 and 199 and 200 and 201 and 202 and 203 and 204 and 205 and 206 and 207 and 208 and 209 and 210 and 211 and 212 and 213 and 214 and 215 and 216 and 217 and 218 and 219 and 220 and 221 and 222 and 223 and 224 and 225 and 226 and 227 and 228 and 229 and 230 and 231 and 232 and 233 and 234 and 235 and 236 and 237 and 238 and 239 and 240 and 241 and 242 and 243 and 244 and 245 and 246 and 247 and 248 and 249 and 250 and 251 and 252 and 253 and 254 and 255 and 256 and 257 and 258 and 259 and 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635 and 636 and 637 and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 REG. NO. 20171																													
1- FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry W. Sturdivant										2a. DATE OF DEATH MONTH DAY YEAR July 11-87		2b. HOUR 10:45 PM																											
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR May 15-01		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 86		IF UNDER 1 YEAR MONTHS DAYS 86		IF UNDER 24 HRS. HOURS MIN. 10:45 PM																													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		MD.																															
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2516 E. Hoffman St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Steel Co.																																	
13a. STATE MD.										13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2516 E. Hoffman St. 21213																							
14. FATHER'S NAME FIRST MIDDLE LAST Richard Sturdivant										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Howell																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. 211-01-9699										17. INFORMANT ADDRESS Marsha Adams 2516 E. Hoffman St.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) undifferentiated carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) unknown DUE TO, OR AS A CONSEQUENCE OF (c) unknown										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that (I) (this hospital) attended the deceased from 7/5 , 19 87 , to 7/11 , 19 87 , that (I) (we) last saw the deceased alive on 7/11 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Dang-VU										DEGREE MD										22c. DATE SIGNED 7/13/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANH DANG-VU										22e. ADDRESS Johns Hopkins Institutions																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal										23b. DATE 7-16-87										23c. NAME OF CEMETERY OR CREMATORY Oak Wood Ctry.										23d. LOCATION CITY OR TOWN COUNTY STATE YOUNGSTOWN Ohio									
24. FUNERAL DIRECTOR NAME Randolph J. Collick										ADDRESS 24316 Oliver St.										25a. DATE REC'D. BY REGISTRAR JUL 16 1987										25b. REGISTRAR'S SIGNATURE									

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and autopsy required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 20172

1. FOR STATE REGISTRAR		4. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST NINA R. SWETT		7a. DATE OF DEATH MONTH DAY YEAR JULY 14, 1987		7b. HOUR 7:30P M	
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 11 20 1938		6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY Katzenberg Brothers	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2515 W. Lombard Street 21223	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Camphor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Woodridge		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-32-9386		17. INFORMANT ADDRESS Michelle Gray 43 N. Catherine Street	
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min.	
		DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>diffuse histiocytic lymphoma</u>						4 months	
		DUE TO, OR AS A CONSEQUENCE OF (c)							
MEDICAL CERTIFICATION		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c):							
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 11</u> , 19 <u>87</u> , to <u>July 14</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>July 14</u> , 19 <u>87</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Yvonne Ottaviano MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) YVONNE OTTAVIANO MD		22e. ADDRESS Johns Hopkins Hospital 600 N. Wolfe St.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/21/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co MD		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue		25. DATE RECEIVED BY REGISTRAR JUL 20 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Spencer P. Sydnor								7		7		19		87		M	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	black	1 21 1947		40 YRS.						7		7		19		87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Md		U S A		WIDOWED		DIVORCED		Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		1710 N. Bentalou St.		Unemployed													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1710 Bentalou Street 21216									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
Stanley		P.		Sydnor		Juanita				Thomas							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		212-46-3956		Mary Haysbert		4012 RoseCrest Road											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u>																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last.																	
(b) _____																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
								STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
<u>Mario F. Golle, Jr.</u>				M.D. Assistant				7-8-87									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Mario F. Golle, Jr., M.D.				111 Penn St., Balto. Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				COUNTY STATE			
Burial				7/13/87		Garrison Forest Vet				Owings Mills				Md			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Wm. C. March F/H West 4300 Wabash Avenue				JUL 13 1987				<u>John Gordon-Randall</u>									

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20174
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PAULINE			2a. DATE OF DEATH MONTH DAY YEAR JULY 21, 1987			2b. HOUR MIN. 6:05AM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 1 1892		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 95		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 147 N. Ellwood Ave. 21224			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown Wentland			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 212-16-0499		17. INFORMANT ADDRESS Anthony Szczybor 5223 Trumps Mill Rd 21206							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 5 min. DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE (several years) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ATRIAL FIBRILLATION, PSEUDOMEMBRANOUS COLITIS, URINARY TRACT INFECTION												
19a. DATE OF OPERATION JULY 21, 1987						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ANEMIA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M.			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE JULY 8, 87 JULY 21, 87						
22a. I certify that (I) (this hospital) attended the deceased from JULY 21, 1987 , to JULY 21, 1987 , that (I) (we) last saw the deceased alive on JULY 21, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Carol S. Ramsey						DEGREE D.O.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CAROL S. RAMSEY D. O.						22e. ADDRESS CHURCH HOSPITAL CORP 100 N. BROADWAY BALTIMORE, MD. 21231						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-24-87		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.				
24. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC. 401 S. CHESTER ST.						25a. DATE REC'D. BY REGISTRAR JUL 23 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, a medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 and return them to the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

BP

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STRENGTH

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RECEIVED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH ESTIMATED	
Bernadine				Szynanski				6 1 19 87	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.	
Female	White	MONTH DAY YEAR		LAST BIRTHDAY		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
		USA		WIDOWED		DIVORCED		Baltimore City	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		4357 Sheldon Avenue							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD				Balt.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4357 Sheldon Avenue 21206	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						Officer Spallone-Northeast District			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
						CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED	
Margarita A. Korell, M.D.				Assistant				6/23/87	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS					
Margarita A. Korell, M.D.				111 Penn St. Balto.MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Removal		6-30-87				CITY OR TOWN			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS				JUL 02 1987				Julia Davidson-Randall	
State Anatomy Board									

20% COTTON FIBER

WALKER BOND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Both pages remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows an injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		REG. NO.		2b. HOUR	
DORIS M. TABELING				7 11 87				11:00P M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE	WHITE	MONTH DAY YEAR 7 3 08		79 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	U.S.A.			BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	LIBERTY MEDICAL CENTER			HOMEMAKER			---		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE					
FIRST MIDDLE LAST FRANCIS TABELING		FIRST MIDDLE LAST LULU HARRINGTON		3040 Brighton Street 21216					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		217-03-4052		Francis G. Tabeling 3040 Brighton St. 21216					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1985</i> to <i>Oct 11, 1987</i> , that (I) (we) last saw the deceased alive on <i>Oct 10, 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Walter R. Welzant</i>		DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Oct 13, 1987</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Welzant		22e. ADDRESS 6100 York Road							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/16/87		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Md.			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR JUL 13 1987		25b. REGISTRAR'S SIGNATURE <i>via Dendron Rader</i>					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20177
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Irene			MIDDLE Taliaferro			LAST			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 25 19 87 MONTH DAY YEAR				2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 07 1910		6. AGE (IN YEARS) (LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 7 26 19 87 MONTH DAY YEAR				2d. HOUR 11:50 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH Baltimore City				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1000 McKean Ave.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic				12b. KIND OF BUSINESS OR INDUSTRY Pvt. Families			
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Maryland 21217 1000 McKean Avenue, Baltimore,							
14. FATHER'S NAME FIRST MIDDLE LAST Frank Taliaferro						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Chaney Brown						16. ADDRESS Bronx, N.Y. 10456					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. 219-30-7646				17. INFORMANT Mr. Mae Julia Seale				ADDRESS 315 E. 167th St. Apt. 5C					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 7-28-87	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell		ADDRESS 111 Penn St., Balto. Md. 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/30/1987		23c. NAME OF CEMETERY OR CREMATORY Family Lot		23d. LOCATION CITY OR TOWN Lancaster, Virginia	
24. FUNERAL HOME NAME ADDRESS 2501 Gwynns Falls Pkwy. Baltimore, Md. 21216				25a. DATE REC'D. BY REGISTRAR AUG 05 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Seale</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 19A. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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NOT RECORDED

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U.S. AIR FORCE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR Film G630 item 18-22 8/11/87									
1- STATE REGISTRAR									
2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 6/ 20/ 19 87									
2b HOUR 8:50									
3 SEX Male									
4 RACE Negro									
5. DATE OF BIRTH MONTH DAY YEAR Jan. 15, 1987									
6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 5 5									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland									
7b CITIZEN OF WHAT COUNTRY? U.S.A.									
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City									
10. CITY OR TOWN OF DEATH Baltimore									
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital									
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baby									
12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Md									
13b. COUNTY --									
13c. CITY OR TOWN Baltimore									
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
13e. STREET ADDRESS 1915 E. Biddle Street									
14. FATHER'S NAME FIRST MIDDLE LAST David Tarallo									
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Serena Matthews									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No									
16b. SOCIAL SECURITY NO. --									
17. INFORMANT ADDRESS Serena Matthews Same									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden infant death syndrome DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that each change of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER									
22c. DATE SIGNED 6/21/87									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial									
23b. DATE 6/24/87									
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park									
23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey, Howard Co. Md.									
24 FUNERAL DIRECTOR NAME ADDRESS Burgee-Henss Funeral Home 3631 Falls Road 21211									
25a. DATE REC'D. BY REGISTRAR JUN 20 1987									
25b. REGISTRAR'S SIGNATURE									

060362 JUL 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH THIS FORM, PAGE 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

080305 JUL 55-01

202 COTTON LABEL

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to removal, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows an injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. STATE REGISTRAR		REG. NO.	
DECEASED NAME (TYPE OR PRINT)		20. DATE OF DEATH MONTH DAY YEAR	
Ethel		7-26-87 2 0 0 0210 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)
FEMALE	CAUCASIAN	APRIL 12, 1905	82 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
RUSSIA	U.S.A.		Baltimore City, MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Union Memorial Hospital	MERCHANT	RETAIL
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13e. STREET ADDRESS / ZIP CODE	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
MARYLAND		BALTIMORE	6429 ELRAY DR., APT. E(21209)
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
SIMON ROTHSTEIN		FANNIE ROTHSTEIN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	
NO		215-42-1990	
17. INFORMANT ADDRESS		17. INFORMANT ADDRESS	
MRS. NORMAN T. RIEF 3202 HATTON RD. 21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
N/A	N/A		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
	19	N/A	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 20</u> , 19 <u>87</u> , to <u>JULY 26</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>JULY 26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE	22c. DATE SIGNED
Ann A. Tran MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	7/26/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Ann A. Tran, M.D.		Union Memorial Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	7/27/87	HEBREW YOUNG MENS - WINNSOR	BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
SOL LEVINSON & BROS., INC.		JUL 31 1987	
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215		25b. REGISTRAR'S SIGNATURE	
		Julia Finkler-Rudolph	

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove Coroner's papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR JAMES FRANCIS TAWNEY		2a. DATE OF DEATH 7/17/87		7 17 87		2b. HOUR 2210 PM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH 10 27 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St Agnes Hospital		12. USUAL OCCUPATIONS (TYPE OF WORK FOR MOST OF WORKING LIFE) ANALYSIS		12b. KIND OF BUSINESS OR INDUSTRY NAVY			
13a. STATE MD		13b. COUNTY HOWARD		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10146 Green Clover Dr. 21043	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM FRANK TAWNEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH LOUISE KRAUSE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1942-1961		17. INFORMANT Doris Tawney 10146 Green Clover Dr. Ellicott City Md. 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancreatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hepatic metastasis and hepatic failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6/28</u> , 19 <u>87</u> , to <u>7/17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Latha R Pillai</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/17/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>PILLAI, LATHA</u>		22e. ADDRESS <u>St Agnes Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Entombment</u>		23b. DATE <u>7/21/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Crestlawn Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Marriottsville Md.</u>			
24. FUNERAL DIRECTOR NAME <u>1630 Edmondson Ave. Catonsville, Md. 21228</u> <u>Leroy M. & Russell C. Witzke Funeral Home</u>		25a. DATE REC'D. BY REGISTRAR <u>JUL 21 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

000300 10 55 81

2000 10 10 10 10

1000 10 10 10 10

1000 10 10 10 10

2500 10 10 10 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 20181			
1. FOR STATE REGISTRAR ROBERT KENNETH TAWNEY				20. DATE OF DEATH MONTH DAY YEAR 7 6 87			
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT K TAWNEY				2b. HOUR 1115A			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 29 20		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 67	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) F.S. KEY MED CTR.		12a. USUAL OCCUPATION (TYPE OF WORK OR OTHER ACTIVITY DURING LIFE) IRONWORKER		12b. KIND OF BUSINESS OR INDUSTRY STEEL	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN MD BALTO. BALTO				13e. STREET ADDRESS 1207 63RD ST. 21237			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE L SMITH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE YEAR OR DATES) YES		16b. SOCIAL SECURITY NO. 234-03-7044		17. INFORMANT NAME ADDRESS JAMES TRUMPS CT 21206 SON, BALTO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE ANTERIOR MI DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 6 JUL 19 87 , to 6 JUL 19 87 , that (I) (we) last saw the deceased alive on 6 JUL 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>C. Morrow</i>				DEGREE		22c. DATE SIGNED 6/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. MORROW MD				22e. ADDRESS F.S. KEY EMERG DEPT.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 07/09/87		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO BALTO MD	
24. FUNERAL DIRECTOR NAME <i>Chasacole</i>				25a. DATE REC'D. BY REGISTRAR JUL 7 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Benson-Rudner</i>	

1-1-57

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

TO THE SECRETARY OF THE

INTERIOR

FOR THE YEAR 1956

AND FOR THE PERIOD

FROM JANUARY 1, 1955

TO DECEMBER 31, 1956

AND FOR THE PERIOD

FROM JANUARY 1, 1954

TO DECEMBER 31, 1955

AND FOR THE PERIOD

FROM JANUARY 1, 1953

TO DECEMBER 31, 1954

AND FOR THE PERIOD

FROM JANUARY 1, 1952

TO DECEMBER 31, 1953

061791 AUG 5 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 00182

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		21. HOUR					
DENISE						TAYLOR		DATE ESTIMATED		7-29-87		19				M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		22. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		23. HOUR	
F		B		12 11 54		32 YRS.						7-29-87		19		3:26					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH													
MD		U.S.A.		WIDOWED		DIVORCED		Baltimore City												MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		2300 McCulloh Street 1st. fl. rear		UNEMPLOYED		N/A															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD				BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1824 NORMAL AVE 21213													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																			
JOHN		H. TAYLOR		BERNICE		HAWKINS															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
NO		216-68-3664		BERNICE TAYLOR		2300 MCCULLOH STREET															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Shotgun wound of chest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
				DUE TO, OR AS A CONSEQUENCE OF																	
				Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)															
				DUE TO, OR AS A CONSEQUENCE OF		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		subject shot															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		(1st floor rear) residence		CITY OR TOWN		COUNTY		STATE									
						2300 McCulloh St.		Baltimore		Maryland											
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from		Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		7-29-87															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
Mario F. Golle, Jr., M.D.		111 Penn Street																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE											
BURIAL		8/4/87		MT. ZION CEMETERY		LANDSDOWNE,		MD													
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
WM. C. MARCH F/H INC.		1101 E. NORTH AVE.		AUG 03 1987		Julia Seaton-Rudace															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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WATERFALL

AUG 20 1961

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20183

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (PRINT) HENRY EDWARD TAYLOR			2a. DATE OF DEATH 7/10/87		2b. HOUR 19:45 M	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 3 31 31	6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Army		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Arbutus	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Floyd Taylor			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alva Cecil			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. Korea-Vietnam 232-46-0612		17. INFORMANT Rita L. Taylor 5623 Selford Rd. 21227		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Ca of larynx; sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from <u>7/10/87</u> to <u>7/10</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/10/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/10/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NITIN MAYUR				22e. ADDRESS ST Agnes Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/14/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Va. Cem. Owings Mills		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				25. DATE REC'D. BY REGISTRAR JUL 16 1987		
25. REGISTRAR'S SIGNATURE <u>[Signature]</u>						

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 20184	
1. DECEASED NAME (TYPE OR PRINT) FIRST MILDRED MIDDLE ADELL LAST TAYLOR		2a. DATE OF DEATH MONTH 7 DAY 3 YEAR 87 2b. HOUR 9 ¹⁵ AM	
3. SEX FEMALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH 1 DAY 12 YEAR 02	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? USA	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE General	9. BALTIMORE CITY OR COUNTY OF DEATH CITY - BALTO. MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY Domestic		
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Robert MIDDLE Norman LAST Allen		15. MOTHER'S MAIDEN NAME FIRST Lillie MIDDLE Branch LAST Martin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-10-4723	17. INFORMANT 21666 201 Congressional Legora N. Taylor Stevenson, Md.	
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subarachnoid Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/29 19 87, to 7/3 19 87, that (I) (we) last saw the deceased alive on 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Dr. Nicholas J. Mamola	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/3/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nicholas J. Mamola		22e. ADDRESS 3001 South Hanover St.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/6/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Balto., A.A. Co., Md.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME McCully Funeral Homes Balto., Md. 21225		25a. DATE REC'D. BY REGISTRAR JUL 08 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

M. A. 2000

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General Belmont
Special Agent
Inspector

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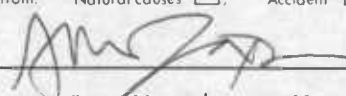
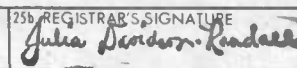
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20185

FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) George		FIRST A.		MIDDLE Thacker		LAST Thacker		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7-21-1987		2b. HOUR 5:00P	
3 SEX Male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 22 59		6 AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 28	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7-21-1987		7d. HOUR 5:00P		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1010 W. Lombard Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1014 W. Lombard St. 21223			
14. FATHER'S NAME FIRST MIDDLE LAST George Thacker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgie M. Sinkler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 217-74-0133		17. INFORMANT ADDRESS Georgie Thacker 1014 W. Lombard St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND OF CHEST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:45PM 7-21-1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1010 W. Lombard Street, Baltimore City, MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 7-22-87			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/27/87		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR 24 1987		25b. REGISTRAR'S SIGNATURE 	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT - PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOIS A THOMAS									
2a. DATE OF DEATH MONTH DAY YEAR 7 11 87		2b. HOUR 5:40 ^A M							
3. SEX F		4. RACE B2		5. DATE OF BIRTH MONTH DAY YEAR 5 2 28		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PILOT MT., N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LIBERTY MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SINAI		12b. KIND OF BUSINESS OR INDUSTRY HOUSEKEEPING	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1615 N. ELLAMONT ST. 21216	
14. FATHER'S NAME FIRST MIDDLE LAST EARNEST MOORE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA HATCHER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS EARL W. THOMAS 1615 N. ELLAMONT ST.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPOTENSION; EMD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>GI BLEEDING, ANEMIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>PORTAL HYPERTENSION ON LIVER CIRRHOSIS; RENAL FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/11/87</u> to <u>7/11/87</u> , that (I) (we) last saw the deceased alive on <u>7/11/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Arbach Woreta MD</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 7/11/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARBACH WORETA						22e. ADDRESS LIBERTY MED CENTER BALTO			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.			
24. FUNERAL DIRECTOR NAME <u>Wendy D. Pyett & Son F.H. 4600 Liberty Heights Ave.</u> ADDRESS						25a. DATE REC'D. BY REGISTRAR JUL 14 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

BP

060646

JUL 24 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO.

20187

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FAIR L THOMPSON			2a. DATE OF DEATH MONTH DAY YEAR 07 20 87		2b. HOUR 7:00 M		
3. SEX MALE		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 03 14 33		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 54	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH BALTO. CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Bell Arnette		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 245-40-9674	
17. INFORMANT ADDRESS James P. Thompson 2823 Mohawk Avenue		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY CRLEST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. DATE OF OPERATION	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>James P. Thompson</i>		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ORESTES MOLDES		22f. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/25/87	
23c. NAME OF CEMETERY OR CREMATORY Eastview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR JUL 23 1987	
25b. REGISTRAR'S SIGNATURE <i>John P. ...</i>		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

20188

87 REG. NO. 0188

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HALE B. THOMPSON			2a. DATE OF DEATH MONTH DAY YEAR 7/28/87		2b. HOUR 11:35 AM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 01 20 17		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bone Season H		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, MO. MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECURITY GUARD		12b. KIND OF BUSINESS OR INDUSTRY GENERAL MOTORS		13a. STREET ADDRESS / ZIP CODE 1001 WICKLOW RD. 21229		
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS J. THOMPSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRENE J. C. WHITE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		
16b. SOCIAL SECURITY NO. 215-10-1516A		17. INFORMANT MRS. FLOSSIE THOMPSON		18. ADDRESS BALTIMORE, MARYLAND 1001 WICKLOW RD. 21229		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) NEURASTHATIC GASTRIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from 7/28 19 87 , to 7/28 19 87 , that (1) (the) last saw the deceased alive on 7/28 19 87 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above; (1) (I) (did) (not) see the body after death.						
22b. SIGNATURE John Shavers		DEGREE PHYSICIAN		22c. DATE SIGNED 7/28/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN SHAVERS		22e. ADDRESS 518 CAMP MEADOW RD 21090				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/31/1987		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PARK		
23d. LOCATION CITY OR TOWN BALTIMORE, MD.		23e. COUNTY BALTIMORE		23f. STATE MD.		
24. NAME OF FUNERAL HOME, INC. 2501 GWYNNS FALLS PKWY. BALTO. MD. 21216		25a. DATE REC'D. BY REGISTRAR AUG 05 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use in the funeral transit permit. These pages should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 REG. NO. 2 0 1 8 9

1. DECEASED NAME (TYPE OR PRINT) JEFFREY Robert THOMPSON			2a. DATE OF DEATH MONTH DAY YEAR JULY 16, 1987		2b. HOUR 2:32 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 15, 1987		6. AGE (IN YEARS LAST BIRTHDAY) 1 Day	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY -
13a. STATE Md.		13b. COUNTY CARROLL	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Joseph Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah Ann Bristow			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Robert Thompson Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) AORTIC STENOSIS & MITRAL REGURGITATION DUE TO, OR AS A CONSEQUENCE OF: (c) CORONARY					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) TEAR IN RIGHT CORONARY ILIAC ARTERY FROM CATHETERIZATION					
19a. DATE OF OPERATION 7-16-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC STENOSIS		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7/16 87 to 7/16 87	
22a. I certify that (I) (this hospital) attended the deceased from 7/16 87 to 7/16 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE MD		22c. DATE SIGNED 7-16-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DUKE EDWARD CAMPBELL		22e. ADDRESS JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-20-87		23c. NAME OF CEMETERY OR CREMATORY Croftdown Cemetery	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Marysville Howard Md.		24. FUNERAL DIRECTOR NAME ADDRESS Harry W. Haight Sykesville, Md.		25. DATE REC'D. BY REGISTRAR JUL 21 1987	
25b. REGISTRAR'S SIGNATURE [Signature]					

The following information was obtained from the records of the
 Department of the Interior, Bureau of Land Management, on July 1, 1955.
 The records show that the land in question was acquired by the
 Government in 1942, and was then used for the purpose of
 establishing a national monument. The land was then transferred to
 the National Park Service, and is now part of the national park system.
 The land is located in the State of California, and is known as the
 [illegible] National Monument. The land is owned by the United States
 Government, and is managed by the National Park Service. The land is
 used for the purpose of preserving the natural resources of the area, and
 for the enjoyment of the public. The land is also used for the purpose of
 conducting scientific research, and for the purpose of providing a place for
 the public to enjoy the natural beauty of the area. The land is a part of
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 conducting scientific research, and for the purpose of providing a place for
 the public to enjoy the natural beauty of the area. The land is a part of
 the national park system, and is managed by the National Park Service.

060458 JUL 28 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove complete pages 1 and 2, and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 20190

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7/17/87		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Black		8/11/1911		75 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
S.C.		U.S.A.				Baltimore, Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Bon Secure Hospital		Retired		Home Maker	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS		21215	
Md.		None		2900 Park Heights Ave.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
James Hall		Carrie Giles					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
-0-0-0-0-0		579-26-3739		Louise Perry		1512 Appleton St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) <u>Acute infarct myocardial infarct</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Coronary artery thrombus</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>Atherosclerosis</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<u>Myocardial</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 6</u> , 19 <u>87</u> , to <u>July 17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>[Signature]</u>						7/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
<u>Marlene J. J. [Signature]</u>		<u>844 N. Cory St 21217</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		7/23/87		Cedar Hill Cemetery		Baltimore, Md	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Law Funeral Home		4611 Park Heights Ave.				JUL 22 1987	
				25b. REGISTRAR'S SIGNATURE		<u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR M	
MARY THORNE				07/07/1987		07-12 P.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE	BLACK	10/9/1918		68 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD MARIOTTSVILLE	U.S.A.			BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTO.	NORTH CHARLES						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD				BALTO.		13e. STREET ADDRESS / ZIP CODE	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		800 N. BENTALOU ST. 21216			
JESSE THORNE		EVA THORNE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		N/A		217-12-8494A EARL S. THORNE P.O. BOX 32			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - RECURRENT VENTRICULAR ARRHYTHMIA - DUE TO, OR AS A CONSEQUENCE OF (b) - CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (c) - CONGESTIVE HEART FAILURE							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 07/07/1987, to 07/07/1987, that (I) (we) last saw the deceased alive on 07/07/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE D.R. Ayers MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY J. MD.		22e. ADDRESS NORTH CHARLES HOSPITAL BALTIMORE, MD 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
CREMATION		7/9/87		WESTVIEW CREMATORY		BALTO., MD.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
D.H. F.H. 4600		Lib. Hgtr		JUL 10 1987		Julia Bender-Rodden	

MEDICAL CERTIFICATION

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05964 JUL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20192

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Eugene Thornton			2a. DATE KNOWN OF DEATH ESTIMATED 7 11 1987		2b. HOUR M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 6 27 1918	6. AGE IN YEARS LAST BIRTHDAY 69	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 7 11 1987
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4510 Manordene Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS BALTIMORE, MD. 4510 MANORDENE RD. 21219	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) LWWII 217-14-9634		17. INFORMANT MR. NATHAN TERRY 3711 HARLEM AVE. BALTIMORE, MD. 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Charles P. Kokes		TITLE (SPECIFY) Assistant		DATE SIGNED 7/11/87	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn St. Balto.MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/17/1987	23c. NAME OF CEMETERY OR CREMATORY CARRISON FOREST VETERAN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.	
24. FUNERAL DIRECTOR'S NAME BAILEY FUNERAL HOME		25. DATE RECEIVED BY REGISTRAR JUL 15 1987		26. REGISTRAR'S SIGNATURE Julia Bender-Randall	
1348 N. CALHOUN ST. BALTO, MD. 21217					

20% COTTON FIBER

DAVID WHITE



101 TO 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, entombment, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 20193			
FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
INEZ		THORNTON						07		12	87	11:45 ^A	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE	BLACK		4 11, 1913		74		MONTHS		DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
VIRGINIA	U. S. A.				BALTIMORE CITY		MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
BALTIMORE	CHURCH HOME HOSP.		Homemaker		Home								
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MARYLAND						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		401 E. 25TH ST. APT. 3B BALTO. MO.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
CHARLES				HILL		MOLLIE BLANCHE HILL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT		BALTIMORE, MD.					
NO.				217-22-2851		RUTH WHITE		2801 WOODLAND AVE.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A., DIABETES, AND C.H.F. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE				DEGREE				ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED			
IMPAGLIATELLI, W.A., M.D.										7/12/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
				CHURCH HOSPITAL 100 N. BROADWAY, BALTIMORE, MD. 21231									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		7/16/1987		EASTVIEW Mem. Pk.		BALTIMORE, MD.							
24. FUNERAL HOME				25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NUTTER FUNERAL HOMES, INC., 2501 GWYNNS FALLS PKWY, BALTO, MD. 21218				JUL 15 1987		Julia Gordon-Randall							

BP _____

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

[Illegible body text]

1
UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR					
LLOYD		H		THORNTON				JULY 3, 1987		2:09A					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		Black		9 MONTH 26 YRS 42		44		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Va.		U.S.A.				BALTIMORE CITY MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		THE JOHNS HOPKINS HOSPITAL						Unemployed							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
Md.				Baltimore				1805 W. Eagle St. 21223							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST		FIRST MIDDLE LAST													
William M. Thornton		Fannie Lewis													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
No		229-58-921		Alma Phillips		1805 Eagle St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST										30 min.					
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										48 hrs.					
(b) Septic Shock															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
Systemic Lupus Erythematosus															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
		19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from 6/24, 19 87, to 7/3, 19 87, that (2) (I) saw the deceased alive on 7/3, 19 87, and that (3) (my) opinion of death occurred on the date and hour and from the causes stated above, (4) (I) did not visit the body after death.															
22b. SIGNATURE										22c. DATE SIGNED					
Barry K. Rayburn MD										7/3/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
BARRY K. RAYBURN										600 N WOLFE ST 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		7-9-87		Mt. Zion Cemetery		Lansdowne,				Md.					
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
March Funeral Home										JUL 7 1987		John P. Rando			
1101 E. North Ave.															

BP

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NOTICE
P

060954 JUL 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 0195

1. DECEASED NAME (TYPE OR PRINT) CLOYD TIBBS			2a. DATE OF DEATH MONTH DAY YEAR 7 21 87			2b. HOUR 10 PM			
3. SEX M		4. RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR 6 7 32		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 12 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY BALTIMORE MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAIL CARRIER		12b. KIND OF BUSINESS OR INDUSTRY GOV.	
13a. STATE MD		13b. COUNTY CHARLES		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE PACEMALL RD 21215	
14. FATHER'S NAME FIRST MIDDLE LAST STAFFORD TIBBS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATE MARBURY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218246826		17. INFORMANT ADDRESS CASSIARA TIBBS RT 4, BOX 7 NANTUCKET, MD. 20662					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)	
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 6/24 19 87 to 7/21 19 87, that (I) (we) lost saw the deceased alive on 7/21 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death.							
22b. SIGNATURE Edwards		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-23-87		23c. NAME OF CEMETERY OR CREMATORY CHURCH OF THE LORD JESUS CHRIST		23d. LOCATION CITY OR TOWN COUNTY STATE IRONSIDES CHARLES MD.	
24. FUNERAL DIRECTOR NAME THORNTON FUNERAL HOME				ADDRESS POMONKEY, MD.		25a. DATE REC'D BY REGISTRAR JUL 27 1987	
						25b. REGISTRAR'S SIGNATURE	

060324 JAN 58 01

100% COTTON FIBER

JESUS CHRIST THE LORD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST FLOYD		MIDDLE L.		LAST TICE		2a. DATE OF DEATH MONTH DAY YEAR 7/7/87	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 2, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 59		7b. HOUR 2:08 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY F.S.K.M.C.			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3020 McElderry 21205	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Tice		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thompson		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 151-22-8042		17. INFORMANT ADDRESS 21224 Mrs. Ines Tice, 3811 Mt. Pleasant Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE, CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS (likely)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ESOPHAGEAL, VOCAL CA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 24-48 hrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. certify that (I) (this hospital) attended the deceased from <u>7/7/87</u> , 19 <u>87</u> , to <u>7/7/87</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>7/7/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Brian Lewis</u>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN LEWIS				22e. ADDRESS 4940 Eastview Ave Baltimore Md 21224					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/10/87		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Joseph N. Zannino, 263 S. Conkling St.				ADDRESS 21224		25a. RECEIVED BY REGISTERED DEATH REGISTRAR'S SIGNATURE JUL 7 1987			

RECEIVED
JULY 1951

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JULY 1951

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JULY 1951

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JULY 1951

060431 JUL 23 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed and filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It should be filed with the funeral director, page 3 should be removed from the certificate. Please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene. Please note: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG.

20197

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Derrick				Timmons	7	19	87		6:57 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male	Negro	MONTH 5 DAY 30 YEAR 66		21	MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	United States			Baltimore city		MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	Bon Secours Hospital		Unemployed						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE					
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	102 N. Smallwood 21223					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
Jesse		Foster		Rebecca Timmons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		219-82-3418		Mrs. Rebecca Cook		102 N. Smallwood Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Artery Thrombosis / Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic renal failure, muscular degeneration, seizure disorder</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1987</u> to <u>July 1987</u> , that (I) (we) last saw the deceased alive on <u>July 1987</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
<u>Alan Watson</u>		MD				7/2/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
<u>Alan Watson</u>		<u>Johns Hopkins Hospital - Baltimore</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)			
<u>BURIAL</u>		<u>7-25-87</u>		<u>Cedar Hill Cem.</u>		<u>Brooklyn</u>		<u>MD</u>	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>Joseph L. Russ</u>		<u>2222 W. North Ave.</u>		<u>JUL 22 1987</u>		<u>Julia Davidson-Randall</u>			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 20198

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William F TITTLE SR			2a. DATE OF DEATH MONTH DAY YEAR 7/21/87			2b. HOUR 20 PM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 26 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HARFORD MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hos.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY HAR		13c. CITY OR TOWN Belted		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5606 Loch Raven Blvd 21237	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE W TITTLE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY E HARRIS				ADDRESS OLD FEDERAL Hill	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212143267A		17. INFORMANT RICHARD H TITTLE		ADDRESS JARRETTSVILLE MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple bleeding sites</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <u>Multiple Strokes</u>									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/18/87</u> 19 <u>87</u> to <u>7/21</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>7/21</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE S Abu Jawdeh						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SALIM ABOU JAOUDE				22e. ADDRESS The Good Samaritan Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7.25.87		23c. NAME OF CEMETERY OR CREMATORY BELAIN MEMORIAL GR		23d. LOCATION CITY OR TOWN COUNTY STATE BELAIN HAR MD			
24. FUNERAL DIRECTOR NAME GEORGE W TITTLE				ADDRESS JARRETTSVILLE MD		25a. DATE REC'D. BY REGISTRAR III 30 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

29

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top of the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

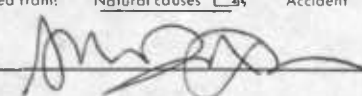
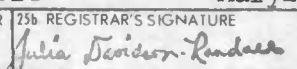
08145 JUL 30 1964

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20199

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST HELEN			MIDDLE May			LAST TOBIN			2a. DATE KNOWN OF DEATH X MONTH DAY YEAR ESTIMATED 7 2 19 87			2b. HOUR M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 28 22		6. AGE (IN YEARS) (LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 2 19 87			2d. HOUR 1:25 P M						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.									
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3446 Hickory Ave. 21211						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland												13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3446 Hickory Avenue 21211			
14. FATHER'S NAME FIRST MIDDLE LAST (unknown)						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown)															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -- 235-18-7743				17. INFORMANT ADDRESS Edward Tobin 3446 Hickory Avenue 21211													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 7-2-87				MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 7/3/87		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery				23d. LOCATION CITY OR TOWN Baltimore		COUNTY Maryland		STATE							
24. FUNERAL DIRECTOR NAME A. Alan Seitz, Jr.						ADDRESS 3818 Roland Ave. 21211				25a. DATE REC'D. BY REGISTRAR JUL 06 1987		25b. REGISTRAR'S SIGNATURE 									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN PART 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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059550 JUL 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

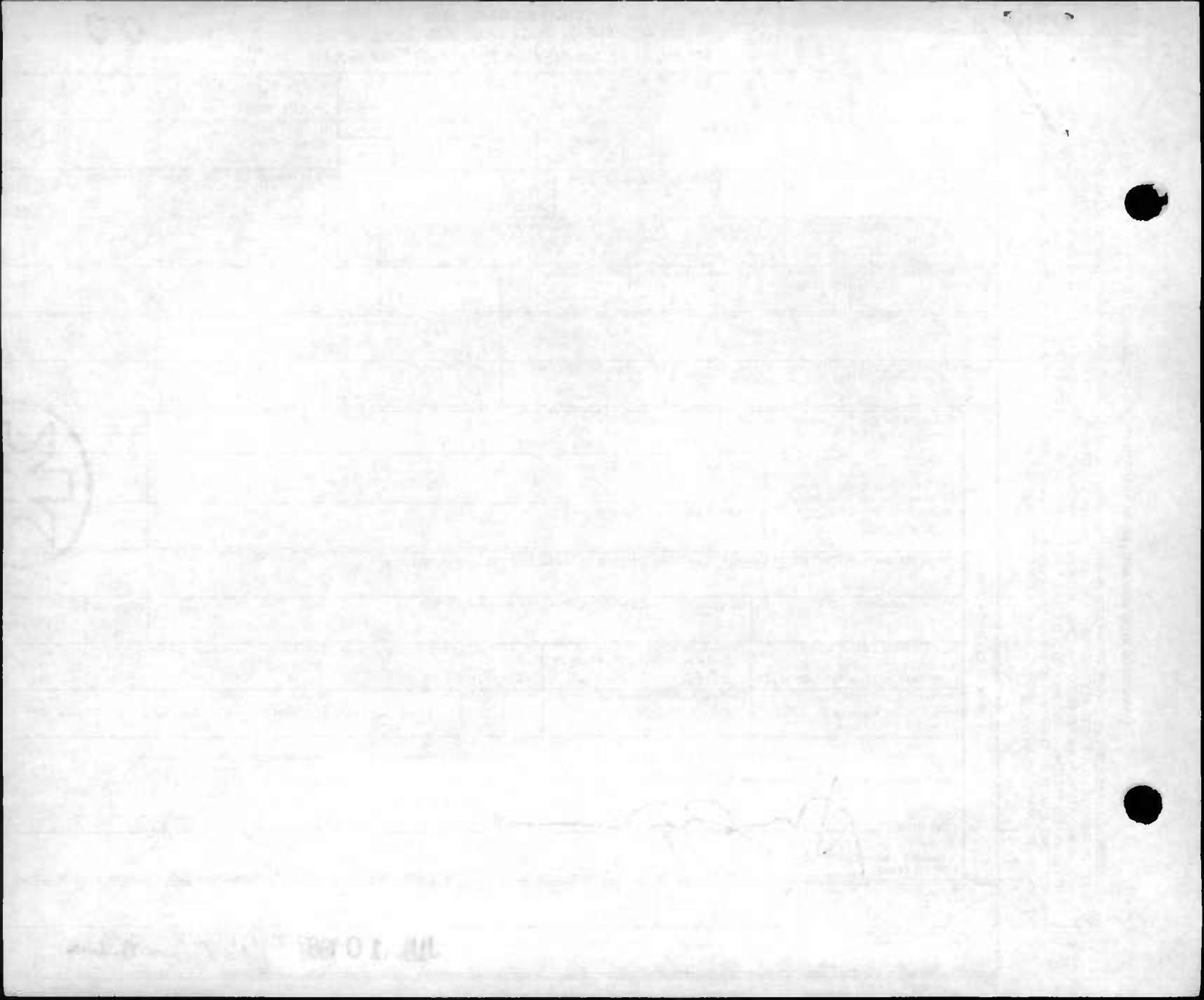
20200
REG NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Bloss Anna Todd			X MONTH DAY YEAR 7-5-87			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR	
FEMALE	BLACK	7 MONTH DAY YEAR 7 4 14	73 YRS.	MONTHS DAYS HOURS MIN		7-5-19 87	1:46 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
S.C.			USA			Baltimore City MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Baltimore			University Hospital			UNEMPLOYED		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MD						Baltimore		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			17. INFORMANT ADDRESS		
Daniel Brown			Anna Johnson			Elease Batey 1016 Richmond Ave. 21212		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			217-20-2890			Elease Batey 1016 Richmond Ave. 21212		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds of chest</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:00AM 7-5-1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION I-95 1/4 mile east of 695 Baltimore County, MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
			M.D. Deputy Chief			7-5-87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Ann M. Dixon, M.D.			111 Penn Street, Balto., MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)	
Burial			7/10/87		ARBUTUS MEMORIAL CEM.		Arbutus, Md.	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D BY REGISTRAR		
William C. March F/H 1101 E. North Ave.						JUL 10 1987		
						25b. REGISTRAR'S SIGNATURE		

07/84
25M

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DHMH - 17
(VR A15 ME (5))



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
EDWARD						TODD		7		23		87				11 ¹² P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
MALE		Black		3 31 96		91 90		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
UNK		USA				BALTIMORE CITY										MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BALTIMORE		SOUTH BALTIMORE GENERAL HOSP		LABORER		BETH STEEL											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE									
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3026 TIOGA PARKWAY								BALTO, MD. 21216	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
RICHMOND		TODD		DELPHIA													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		213-07-1421		MRS. GLADYST. RICE		BALTIMORE, MD.										3659 FOREST HILL RD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		IMMEDIATE CAUSE (a)		CARDIOPULMONARY ARREST													
		DUE TO, OR AS A CONSEQUENCE OF		ASPIRATION PNEUMONIA													
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		SEPSIS											
		(c)															
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION													
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED											
ROBERT FEINGOLD						7/23/87											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
ROBERT FEINGOLD, M.D.		3001 S. HANOVER ST. BALTO, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
BURIAL		7/28/1987		MD. NATIONAL MEM. PK		LAUREL, MD.											
24. FUNERAL HOME OR ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
NUTTER FUNERAL HOMES, INC.		JUL 28 1987		Lisa T. ...													
2501 GWYNNS FALLS PKWY. BALTO, MD. 21216																	

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061788 AUG -587

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20202

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVA TOPP			2a. DATE OF DEATH MONTH DAY YEAR JULY 30, 1987		2b. HOUR MIN. 6:10P		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 3-08-11		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M.D.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chweth Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE M.D.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT Rev. Johnson P.O. Box 3311		ADDRESS #21213		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMMORHAGE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JULY 30, 1987 to JULY 30, 1987 , that (I) (we) lost saw the deceased alive on JULY 30, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jonathan D. Kushner		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8/4/87		23c. NAME OF CEMETERY OR CREMATORY Eastview Cem		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. M.D.	
24. FUNERAL DIRECTOR NAME Betts Funeral Home		ADDRESS 1129 N. Carolina		25a. DATE REC'D. BY REGISTRAR AUG 04 1987		25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

081788 AUG-2-81

EGW: COACH 3089

12/14/81

12/14/81

12/14/81

060867 JUL 28 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20203

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA MARGARET TOWNS			2a. DATE OF DEATH MONTH DAY YEAR 7 25 87		2b. HOUR 1:15 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 14 95		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		
14. FATHER'S NAME FIRST MIDDLE LAST George Ziegler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Yakel		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Linen Supply		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-32-5603		17. INFORMANT ADDRESS Harold C. Towns 5 University Ave. 21228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary congestion & edema</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Probable bilateral bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Left cerebral infarct</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Renal artery stenosis & atrophy R kidney & hypertensive heart disease</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>6/26</i> 19 <i>87</i> to <i>7/25</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>7/25</i> 19 <i>87</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE <i>William J. Hicken</i>				22c. DATE SIGNED <i>7/25/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm. J. Hicken, MD</i>				22e. ADDRESS <i>St Agnes Hospital</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/29/87		23c. NAME OF CEMETERY OR CREMATORY Loudon park Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				
25a. DATE REC'D. BY REGISTRAR JUL 27 1987				25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

000827 JUL 59 85

RECEIVED JUL 10 1959

U.S. AIR FORCE

100-100000-1

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061483 JUL 30 '87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20204
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES EDWARD TOWNSLEY			2a. DATE OF DEATH MONTH DAY YEAR JULY 30, 1987		2b. HOUR A M 1:27 A
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 27, 1941		6. AGE (IN YEARS LAST BIRTHDAY) 46	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Iron Worker		12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Forest Hill	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Marion Townsley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Agnes Ward		13e. STREET ADDRESS / ZIP CODE 1610 Rebecca Court 21050	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Vietnam		16b. SOCIAL SECURITY NO. 213-38-8653		17. INFORMANT ADDRESS Carol W. Townsley, 100 Oak Moore Court Bel Air, Md. 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Meningitis					14 days
DUE TO, OR AS A CONSEQUENCE OF (c) Sepsis					14 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION 7/17/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Perforation		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from July 14 , 19 87 , to July 30 , 19 87 , that (1) (we) lost saw the deceased alive on July 30 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jeffrey A. Drebin		DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey A. Drebin		22e. ADDRESS Dept. of Surgery, Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Aug. 1, 1987	23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill Harford Md.
24. FUNERAL DIRECTOR Howard K. McComas III, Abingdon, Md. 21009 Foster's Funeral Home		25a. DATE REC'D. BY REGISTRAR JUL 31 1987		25b. REGISTRAR'S SIGNATURE Det Air, MD	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HOSPITAL OR TENTING PHYSICIAN: This requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TOWNSLEY, CHARLES EDWARD

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as a burial-transit permit. Then please remove carbon pages 1 and 2 and send them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

081483 JUL 30 03

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2:10 AM 10 15 30
LOANER CHARGE

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JUL 31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, and 4. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABLE (Johnson) TRAYLOR			2a. DATE OF DEATH MONTH DAY YEAR JULY 14, 1987		2b. HOUR 4:45A M
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 8 23 12	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1820 N. Collington Ave. 21213	
14. FATHER'S NAME FIRST MIDDLE LAST Mathews Watts		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bettie Scott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-20-9723	17. INFORMANT ADDRESS Howard Shavers 605 Benninghaus Rd. 21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN.
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>					4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> 19 <u>87</u> to <u>7/14</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/14</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Howard Baum</u>		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD BAUM		22e. ADDRESS THE JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-18-87	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetary	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, MD	25a. DATE REC'D. BY REGISTRAR JUL 17 1987	
24. FUNERAL DIRECTOR NAME March Funeral Homes, Inc.		ADDRESS 1101 E. North Ave.		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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ITEM NO. 1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. **20206**
DATE OF DEATH **July 25, 1987** 25 HOUR **1202 AM**
OT 25 87

1. DECEASED NAME (TYPE OR PRINT) PAUL BALDWIN TRIPLETT		2a. DATE OF DEATH	
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 15, 1916	6. AGE (IN YEARS LAST BIRTHDAY) 71
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Loch Raven Veterans Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Emp.
13a. STATE Maryland		13b. COUNTY Arundel	13c. CITY OR TOWN Baltimore
14. FATHER'S NAME John	15. MOTHER'S MAIDEN NAME Vivian Whitacher	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. W.W. II 275/03/1029	17. INFORMANT (Wife) Mrs. Margaret H. Triplett		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myelogenous Leukemia in Blast phase		15 month
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from July 20 , 19 87 , to July 25 , 19 87 , that (I) (we) last saw the deceased alive on July 25 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			
22b. SIGNATURE Lawrence E. Kass	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 7/25/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence E. Kass		22e. ADDRESS Loch Raven VA Hosp Loch Raven Blvd	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment	23b. DATE July 28, 1987	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland
24. FUNERAL DIRECTOR'S NAME R. A. Blyskin		25a. DATE REC'D. BY REGISTRAR JUL 28 1987	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>
1 Second Ave. S. W. Singleton Funeral Home, Glen Burnie, Md.			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove completed pages 1 and 2 and place them in the envelope provided with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

20207
 87 REG NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ESTELLE M. TROWER		7-9-87		8:43 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	BLACK	11 30 1900	86	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
VIRGINIA	U. S. A.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE	LIBERTY MEDICAL CENTER	Homemaker	Home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
MARYLAND		BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	BALTO. MD. 3514 CLIFTON AVE. 21216	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
SHERDRICK	WADDY	CLARA CARTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
NO.	215-32-2609	MRS. BALTIMORE, MARYLAND LILLIAN L. HALE 3514 CLIFTON AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) SEPTIC SHOCK.					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
SEIZURE - RESPIRATORY FAILURE					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 5-17 19 87 to 7-9 19 87, that (I) (we) last saw the deceased alive on 7-9 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
BICH T DUONG		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		7-9-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
BICH T DUONG		LIBERTY MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY STATE	
BURIAL	7/17/1987	BALTIMORE NATIONAL CEM.	BALTIMORE	MD.	
24. FUNERAL HOME (NAME AND ADDRESS)		25. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NORTHERN FUNERAL HOMES, INC., 2501 GWYNNS FALLS PKWY, BALTO. MD. 21216		JUL 15 1987		Julia Denton-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the following pages from the certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause of death, the medical examiner must be notified at once.

061475 JUL 30 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH20208
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED MATED			MONTH DAY YEAR			2b. HOUR			
HILDA M. TUCKER						7-27-87 19						M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female		Black		05-29-24		63 YRS.						7-27-87 19		9:05	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Balto., Md.				USA								Baltimore City MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				902 W. Lexington Street				Housekeeper							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland						Baltimore				902 W. Lexington St. 21223					
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
James Muse				Hazel Holmes											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS							
No				217-22-0958				Stanley Holmes 26 N. Monroe							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Margaret A. Korell</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 7-30-87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Margarita A. Korell, M.D.				111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				08-01-87				Mt. Calvary Cemetery				Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Brown/Thompson F.H.				P.O. Box 4433				JUL 31 1987				<u>John Davidson</u>			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 100-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TENESTMENT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

061452 JUL 30 81

RECEIVED

NOTICE

DAVID

WILKINSON



JUL 23 81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO. 87 30209

1. DECEASED NAME (TYPE OR PRINT) Lilian Campbell TULLOCH			2a. DATE OF DEATH MONTH DAY YEAR July 17, 1987		2b. HOUR 3:45P M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Mar. 12 1921		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. To V.P.	12b. KIND OF BUSINESS OR INDUSTRY Banking	
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3900 N. Charles St. 21218
14. FATHER'S NAME FIRST MIDDLE LAST John Tulloch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lily Ann Campbell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No.		16b. SOCIAL SECURITY NO. 213-16-5309	17. INFORMANT ADDRESS Eugene W. Mayhorne Balto., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac shock					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour
DUE TO, OR AS A CONSEQUENCE OF (b) Severe respiratory failure					48 hours
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive pulmonary disease					10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hemoptysis secondary to tuberculosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 21, 1987, to July 17, 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 17, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE Wilfred H. Townshend, M.D.				22c. DATE SIGNED 7/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilfred H. Townshend, M.D.				22e. ADDRESS c/o Maryland General Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-20-87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons			25a. DATE REC'D. BY REGISTRAR JUL 21 1987		
			25b. REGISTRAR'S SIGNATURE Julia Deardon-Randall		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

CONFIDENTIAL

TO: DIRECTOR, FBI (100-441100) FROM: SAC, NEW YORK (100-158800) (P)

U.S.A.

RE: JAMES EARL RAY, AKA; V.F.

RE: JAMES EARL RAY, AKA; V.F.

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RE: JAMES EARL RAY, AKA; V.F.

RE: JAMES EARL RAY, AKA; V.F.

RE: JAMES EARL RAY, AKA; V.F.

RE: JAMES EARL RAY, AKA; V.F.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 REG. NO. 20210	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CRESSWELL TURNER					2a. DATE OF DEATH MONTH DAY YEAR JUNE 29, 1987			2b. HOUR 8:15^P			
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 9 26 09		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.					
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5220 York Rd. 21212			
14. FATHER'S NAME FIRST MIDDLE LAST HENRY TURNER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-01-8389		17. INFORMANT ADDRESS CHURCH HOME HOSPITAL							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from JUNE 29, 1987 to JUNE 29, 1987 , that (I) (we) lost saw the deceased alive on JUNE 29, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Beena Najpal					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B BEENA NAJPAL					22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL			23b. DATE 7-3-87		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS State Anatomy Board					25a. DATE REC'D. BY REGISTRAR JUL 8 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

BP

12

REPORT OF THE

COMMISSIONER

OF THE BUREAU

OF PLANT INDUSTRY

059271 JUL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20211

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Welford			2a. DATE KNOWN OF DEATH ESTIMATED 7-4-1987			2b. HOUR 8:55 A.M.		
3. SEX male	4. RACE Col 2	5. DATE OF BIRTH MONTH DAY YEAR 4-9-39	6. AGE IN YEARS (LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 7-5-1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1804 N. Smallwood				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Road Worker		12b. KIND OF BUSINESS OR INDUSTRY State of Maryland
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2211 Westwood Ave		
14. FATHER'S NAME John			15. MOTHER'S MAIDEN NAME Louise		16. ADDRESS Mrs. Geraldine Wheeler 1134 McKennan Ave			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-62-5462		17. INFORMANT Mrs. Geraldine Wheeler			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Dilated cardiomyopathy

DUETO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) _____
DUETO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL
SIGNATURE

TITLE (SPECIFY)

M.D. Deputy Chief MEDICAL EXAMINER

DATE SIGNED 7-5-87

EXAMINER'S NAME
(TYPE OR PRINT)

Ann M. Dixon, M.D.

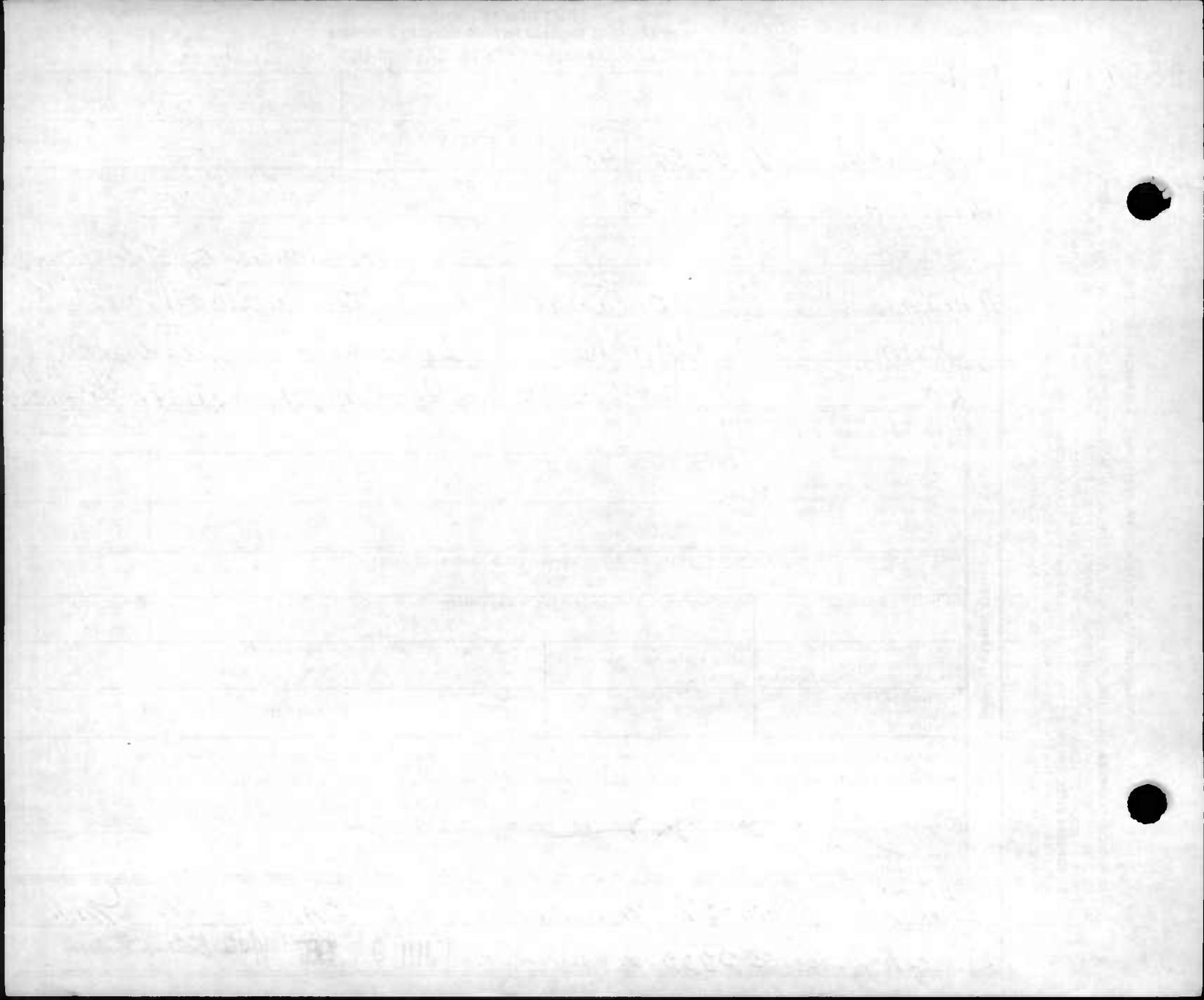
ADDRESS 111 Penn Street, Balto., MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-10-87	23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial	23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co. Md.
24. FUNERAL DIRECTOR NAME Joseph L. Russ		25a. DATE REC'D. BY REGISTRAR JUL 9 1987	
ADDRESS 2222 W. North Ave.		25b. REGISTRAR'S SIGNATURE Julia Benson-Randall	

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20212

REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME

FIRST

MIDDLE

LAST

Irene

C.

Turnipseed

1. SEX

female

4. RACE

black

5. DATE OF BIRTH

MONTH

DAY

YEAR

9

24

1924

6. AGE (IN YEARS LAST BIRTHDAY)

62

YRS

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore city

MD.

10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

West Virginia

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Villa St Michael N/H

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md

13b. COUNTY

BALTO

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES

NO

13e. STREET ADDRESS / ZIP CODE

6839 West Ridge Road 21207

14. FATHER'S NAME

FIRST

Elie

MIDDLE

LAST

Jordan

15. MOTHER'S MAIDEN NAME

FIRST

Irene

MIDDLE

LAST

Gray

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

218-12-0381

17. INFORMANT

ADDRESS

Henry Turnipseed

6839 West Ridge Road

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Chronic Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES

NO

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES

NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21i. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 6/6, 1987, to 7-16, 1987, that (I) (we) last saw the deceased alive on 7-5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN

MEDICAL DIRECTOR

STAFF PHYSICIAN

22c. DATE SIGNED

7-7-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Harold B. BOB

22e. ADDRESS

7220 Park Heights Ave 2120 F

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

7/20/87

23c. NAME OF CEMETERY OR CREMATORY

Lakeview Memorial

23d. LOCATION

Sykesville

COUNTY

MD

24. FUNERAL DIRECTOR

NAME
Wm. C. March F/H West 4300 Wabash Avenue

25a. DATE REC'D. BY REGISTRAR

JUL 17 1987

25b. REGISTRAR'S SIGNATURE

Julia Borden-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please enclose carbon copies. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

0222887 JUL 50 01

8



AND BOND

WATERFORD

059371 JUL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

20213

1. DECEASED NAME (TYPE OR PRINT) James Edward Tuttle		2a. DATE OF DEATH MONTH DAY YEAR 7-6-87		2b. HOUR 4:45AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 06 19 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4113 Falls Road 21211
14. FATHER'S NAME FIRST MIDDLE LAST James Edward Tuttle		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Wiley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Milton Hipsley 37th St. & Hickory Ave. 21211	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>intracranial bleed</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coagulopathy</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 12 hours 1 year.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Liver failure</u>					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 5</u> , 19 <u>87</u> , to <u>JULY 6</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>JULY 5</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Ray S. Setharaman</u>				22c. DATE SIGNED July 6, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/13/87		23c. NAME OF CEMETERY OR CREMATORY Moreland mem. Pk.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		23e. DATE REC'D. BY REGISTRAR JUL 13 1987			
24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211		25. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

E1606

110M + 1800



100 1 2 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20214

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN LOUIS TWIST				2a. DATE OF DEATH MONTH DAY YEAR JULY 25, 1987		2b. HOUR 1858 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 09 1921		6. AGE (IN YEARS LAST BIRTHDAY) YRS 66	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WAREHOUSEMAN		12b. KIND OF BUSINESS OR INDUSTRY FACTORY	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN ARBUTUS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY TWIST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLYN GEISELMAN		13e. STREET ADDRESS / ZIP CODE 4312 HIGHVIEW AVENUE 21229			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW2		17. INFORMANT ADDRESS JOANNE URICH 1507 BARRETT ROAD 21207			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral Above Knee Amputations</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Atherosclerotic coronary artery disease; peptic ulcer disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that the deceased attended the hospital from <u>July 21</u> 19 <u>87</u> to <u>July 25</u> 19 <u>87</u> , that he (we) last saw the deceased alive on <u>July 25</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.							
23a. SIGNATURE <u>Barbara Socha</u> MD				DEGREE		22c. DATE SIGNED <u>7/25/87</u>	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) BARBARA SOCHA				22e. ADDRESS 900 S CATON AVE. BALTO. MD 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 07/29/87		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME AMBROSE FUNERAL HOME				25a. DATE REC'D. BY REGISTRAR JUL 28 1987			
25b. REGISTRAR'S SIGNATURE							

BP

021103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonized pages. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20215

1- FOR
STATE
REGISTRAR

FRANK P. TYNAN

1. DECEASED NAME
(TYPE OR PRINT)

Frank P. TYNAN

2a. DATE OF DEATH MONTH 7 DAY 13 YEAR 87 7b. HOUR

7 13 87 9:30 P.M.

3. SEX

Male

4. RACE

white

5. DATE OF BIRTH

MONTH 7 DAY 15 YEAR 14

6. AGE (IN YEARS LAST BIRTHDAY)

72

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

CALIFORNIA

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

University of Maryland Shock Trauma

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

ENGINEER

12b. KIND OF BUSINESS OR INDUSTRY

MERCHANT MARINE

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

BALTIMORE

13c. CITY OR TOWN

ARBUTUS

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒ XX

13e. STREET ADDRESS / ZIP CODE

5554 OAKland Rd 21227

14. FATHER'S NAME

FRANCIS

MIDDLE

LAST

TYNAN

15. MOTHER'S MAIDEN NAME

ROSE

ADDRESS

McCLOREY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

YES

16b. SOCIAL SECURITY NO.

1933-1937

17. INFORMANT

572-18-8907

EILEEN TYNAN

SAME AS # 13

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

peritonitis and bacteremia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) bleeding pyloric ulcer

2 1/2 wks

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

renal failure

19a. DATE OF OPERATION

6/28, 7/13, 7/6/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

bleeding ulcer, peritonitis

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (this hospital) attended the deceased from 6/27 19 87, to 7/13 19 87, that (we) last saw the deceased alive on 7/13 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)

22b. SIGNATURE

Timothy J. Low

DEGREE

M.D.

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

7/13/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Timothy J. Low

22e. ADDRESS

22 So Greene St Balt, MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

7/16/87

23c. NAME OF CEMETERY OR CREMATORY

MARYLAND VETERANS

23d. LOCATION

OWINGS MILLS

GARRISON FOREST

MARYLAND

24. FUNERAL DIRECTOR

LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A.

1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228

25a. DATE REC'D. BY REGISTRAR

JUL 16 1987

25b. REGISTRAR'S SIGNATURE

Lia Gordon-Randall

0200022 JUL 17 68

100-100000

JUL 18 1968

060402 JUL 23 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return the certificate to the Division of Vital Records. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified by page 4.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR2. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

CAROLINE

Margaret

UHLIG

3. SEX

F

4. RACE

W

5. DATE OF BIRTH

MONTH

DAY

YEAR

10

2

18

6. AGE (IN YEARS LAST BIRTHDAY)

68

YRS

7. IF UNDER 1 YEAR

MONTHS

DAYS

8. IF UNDER 24 HRS

HOURS

MIN.

7 20 87

10:15 P

7a. BIRTHPLACE

(STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE

CITY

MD

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

ST AGNES HOSPITAL

12a. USUAL OCCUPATION

Cosmetologist Aide

12b. KIND OF BUSINESS OR INDUSTRY

Beauty Shop

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Arbutus

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

1254 June Road 21227

14. FATHER'S NAME

Peter

MIDDLE

Lux

15. MOTHER'S MAIDEN NAME

Margaret

MIDDLE

Hoffman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

No

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

215-01-7367

17. INFORMANT

Joseph P. Uhlig, 1254 June Road

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Distant Metastasis of Lung Ca.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORK ☐NOT WHILE ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME STREET FACTORY, OFFICE, FARM, ETC)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from July 20, 19 87, to July 20, 19 87, that (I) (we) last saw the deceased alive on July 20, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☒

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Dr. M. K. Ro

22e. ADDRESS

St. Agnes Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Entombment

23b. DATE

7/24/87

23c. NAME OF CEMETERY OR CREMATORY

Loudon Park Mausoleum

23d. LOCATION

CITY OR TOWN

Baltimore

COUNTY

STATE

Maryland

24. FUNERAL DIRECTOR

NAME

Hubbard Funeral Home, Inc., 4107 Wilkens Ave.

ADDRESS

21229

25a. DATE REC'D. BY REGISTRAR

JUL 22 1987

25b. REGISTRAR'S SIGNATURE

Julia Davis

000405 JUL 53 61



061870 AUG 17 07

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 20217

1. DECEASED NAME (TYPE OR PRINT) Elizabeth M. Urlahs			2a. DATE OF DEATH MONTH DAY YEAR 7/30/87		2b. HOUR 1:35P
3. SEX F	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 1-19-1896		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med. Ctr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 923 S. Curley St.
14. FATHER'S NAME FIRST MIDDLE LAST SYLVESTER POTUNAS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA BRAILER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-58-8829		17. INFORMANT VIRGINIA WILCOX	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CVA, cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) HTN, CAD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Wendy Matis MD		DEGREE		22c. DATE SIGNED 7/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wendy Matis MD		22e. ADDRESS FSK Hosp., 4940 Eastern Ave, Balto. MD			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL	23b. DATE 8-3-87	23c. NAME OF CEMETERY OR CREMATORY SAC. HEART OF JESUS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD	
24. FUNERAL DIRECTOR NAME THOMAS J. SKARDA		25a. DATE REC'D. BY REGISTRAR AUG 3 1987		25b. REGISTRAR'S SIGNATURE J. Gordon-Randall	

MEDICAL CERTIFICATION

081870 YOC-587

#23b,c,per F.H. 10/2/87 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

87 REG. NO. 20218

06151T AUG -4 87

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) KATHERINE T. VECHIO			2a. DATE OF DEATH MONTH DAY YEAR 07 28 87		2b. HOUR 0407 M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 01 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED/HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE MD		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN GRAFF		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY RAPPELT		13. STREET ADDRESS / ZIP CODE 863 MILDRED AVE. ; 21222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 215-0105-25A		17. INFORMANT ADDRESS NORMA BROWN 863 MILDRED AVE. BALT. MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONGESTIVE HEART FAILURE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/23 , 19 87 , to 7/28 , 19 87 , that (I) (we) lost saw the deceased alive on 7/28 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert R Ramirez				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-28-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT R. RAMIREZ				22e. ADDRESS 3001 S. Hanover St. BALT. MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/30/87		23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME ADDRESS WALTER DABROWSKI 1005 DUNDALK AVE				25a. DATE REC'D. BY REGISTRAR AUG 3 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers, page 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

081211 AUG - 85

100% COLLOR LICKS

061313 JUL 30 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22219

1. DECEASED NAME (TYPE OR PRINT) Mary Veney		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7/ 29/ 19 87		2b. HOUR M P
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 13 05 82	6. AGE (IN YEARS) LAST BIRTHDAY 82 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secour Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO.	13d. STREET ADDRESS 1927 Penrose Ave
14. FATHER'S NAME FIRST MIDDLE LAST James Veney		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 225-12-4944	17. INFORMANT Pauline Veney 1927 Penrose Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		MEDICAL EXAMINER Assistant		DATE SIGNED 7/30/87
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/1/87	23c. NAME OF CEMETERY OR CREMATORY Mulberry B.C. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Emmorton, Virginia
24. FUNERAL DIRECTOR NAME William C. Brown		ADDRESS 1806 W. North Ave		25a. DATE RECD. BY REGISTRAR JUL 30 1987
				25b. REGISTRAR'S SIGNATURE Julia Sanders-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH EXAMINER'S REPORT. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

081313 JUL 30 87

081313 JUL 30 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James J. Vicchio					2a. DATE OF DEATH MONTH DAY YEAR 07 10 87					2b. HOUR 3 ³¹ A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 11 1912		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Grounds/Supervisor city parks dept			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 436 W. 23rd Street 21211			
14. FATHER'S NAME FIRST MIDDLE LAST John Vicchio				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Detorie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-07-6608		17. INFORMANT ADDRESS Rose M. Vicchio 436 W. 23rd Street 21211					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pulmonary embolus x 2</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Possible saddle embolus</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30-45 mins 24 hours 30-45 mins	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a <u>SEVERE MYOCARDIAL DYSFUNCTION / I.C.O. P.D.</u>											
19a. DATE OF OPERATION 6-30-87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF THE SIGMOID				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 15</u> , 19 <u>87</u> , to <u>JULY 10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>JULY 10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>David V. Nasrallah</u>								DEGREE MD		22c. DATE SIGNED 07/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID V. NASRALLAH								22e. ADDRESS 901 E. UNIV. PKWY. BALTO. MD 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/13/87		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Maryland			
24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home						ADDRESS 3631 Falls Road		25a. DATE REC'D. BY REGISTRAR JUL 14 1987			
								25b. REGISTRAR'S SIGNATURE <u>Julia Strickland</u>			

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

OFFICE OF THE
CHIEF OF BUREAU

Washington, D. C.
July 14, 1914

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst. regarding the matter of the proposed extension of the contract for the purchase of the land for the establishment of a new experimental station for the Bureau of Plant Industry.

The matter is being considered by the Board of Plant Industry and the results will be communicated to you as soon as possible.

Very respectfully,
J. H. H. H.

060975 JUL 28 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

87 20221

1. FOR STATE REGISTRAR		2. BASED NAME		FIRST		MIDDLE		LAST		REG. NO.		3. DATE KNOWN OF DEATH		4. MONTH		5. DAY		6. YEAR		7. HOUR	
		Josephine A. Vigilante										7/ 23/ 1987									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		8. MONTH		9. DAY		10. YEAR		11. HOUR	
FEMALE		WHITE		APRIL 24, 1908		79 YRS.						7/ 23/ 1987								12. 36	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
CALIFORNIA		U.S.A.										Baltimore City,									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
Baltimore		3006 Poplar Terrace		HOUSE WIFE		OWN HOME															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MARYLAND		BALTO. CITY		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3006 POPLAR TERRACE													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
UNKNOWN		DELIA L. BONIFACE		NO		216-46-3073		ALBERT VIGILANTE		3006 POPLAR TERRACE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerotic Cardiovascular Disease															
				(b)		DUE TO, OR AS A CONSEQUENCE OF															
				(c)		DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?																	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
		HOUR A.M. MONTH DAY YEAR																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION																	
				CITY OR TOWN		COUNTY		STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																			
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED																	
Dennis F. Smyth, M.D.		Assistant		7/23/87																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																			
111 Penn St.																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE											
BURIAL		7/27/87		LORRAINE PARK MAUSOLEUM		WOODLAWN		BALTIMORE		MARYLAND											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
LEROY M. & RUSSELL C. WITZKE FUNERAL HOME OF CATONSVILLE		JUL 27 1987		late																	
1630 EDMONDSON AVE. CATONSVILLE MD. 21228																					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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JUL 13 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

RELEASED NON MED DR MARIO GOLLE PER MR LAWYER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. STATE REGISTRAR Arvella Lillian Vingsen					87 20222				
1. DECEASED NAME (TYPE OR PRINT) Arvella Vingsen					2a. DATE OF DEATH MONTH DAY YEAR 7/8/87			2b. HOUR 1132 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 22 13		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City (BALTIMORE) MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Middle River					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10051 Pulaski Hwy 21220		
14. FATHER'S NAME FIRST MIDDLE LAST William Mack					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Leppo				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 54 1171		17. INFORMANT ADDRESS Stanley Vingsen, Sr. Husband Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Ruptured Thoracic Abdominal Aneurysm DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH April 9, 87
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION July 8, 87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured Thoracic Abdominal Aneurysm				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 8 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Spontaneous rupture					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Field		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 8, 19 87 to July 8, 19 87 , that (I) (we) last saw the deceased alive on July 8, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James G. Ross				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 7/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James G. Ross				22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 7/10/87		23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Belair, Md.		
24. FUNERAL DIRECTOR Franczinski Funeral Home PA 1107 Old Eastern Ave 21221				25a. DATE REC'D BY REGISTRAR JUL 10 1987			25b. REGISTRAR'S SIGNATURE [Signature]		

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JUL 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20223

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WARREN W. VOELKER			2. DATE OF DEATH MONTH DAY YEAR 7-18-87		7b. HOUR 10am M								
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10-10-12		6. AGE (IN YEARS LAST BIRTHDAY) 74 yrs. YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1223 Quantril Way				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Balto. City					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.						13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1223 Quantril Way 21205	
14. FATHER'S NAME FIRST MIDDLE LAST John Voelker						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF NOT IN U.S. ARMED FORCES) WWII 212-14-I290		17. INFORMANT ADDRESS Eva Harris 4014 Echodale Avenue 21206									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> , 19 <u>84</u> , to <u>6/18</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>5/4</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Carla Wulf Rosenthal</u>								DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/20/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Carla Rosenthal								22e. ADDRESS Brehms Medical Center					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7-21-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL HOME Schunke Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213								25a. DATE REC'D. BY REGISTRAR JUL 24 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to transportation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of same.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20224

1. DECEASED NAME (TYPE OR PRINT) ELAINE VOID		2. DATE OF DEATH MONTH DAY YEAR 7/5/87 9:55 P.M.	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 10 10 47	6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.	13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 3513 Wood Brook Ave 21217
14. FATHER'S NAME FIRST MIDDLE LAST Willie Void	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH FOGLEE	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 215-52-2549	17. INFORMANT Estelle Voio		ADDRESS 1812 Whitmore Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Retropharyngeal Tumor</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Status Epilepticus</u>			
19a. DATE OF OPERATION 4/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of mouth	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/4/87 to 7/5/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If fatal I will not view the body after death.)			
22b. SIGNATURE P. E. CORREA		DEGREE MD	22c. DATE SIGNED 7-5-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. E. CORREA		22e. ADDRESS c/o LIBERTY MEDICAL CENTER	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-10-87	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD.
24. FUNERAL DIRECTOR NAME March Funeral Home		25. DATE REC'D. BY REGISTRAR JUL 14 1987	
ADDRESS 1101 E. North Ave.		25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandora	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is checked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vernell Waddell		20. DATE OF DEATH MONTH DAY YEAR 7/1/87		REG. NO. 20225 155 AM	
3. SEX F	4. RACE B 2	5. DATE OF BIRTH MONTH DAY YEAR 11 13 31	6. AGE (IN YEARS LAST BIRTHDAY) 55	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (ADDRESS) University Hospital.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed	12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE MD	13b. COUNTY Balt	13c. CITY OR TOWN Balt	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1335 N. STOCKTON ST. 21217	
14. FATHER'S NAME FIRST MIDDLE LAST Alonzo MOSES	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Sales		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 218-26-2002		
16b. SOCIAL SECURITY NO. 218-26-2002		17. INFORMANT ADDRESS Mrs Paula Smith 1335 N. Stockton St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) myasthenia esophageal CA DUE TO, OR AS A CONSEQUENCE OF (c) - Approximate interval between onset and death: 4 hours 8 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: -					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR July 1 19 87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 10 19 87 to July 1 19 87 , that (I) (we) last saw the deceased alive on July 1 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.					
22b. SIGNATURE Lisa A Dimarzio MD	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 7/1/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LISA DIMARZIO MD.	22e. ADDRESS 22 S. Greene St., Balt MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-8-87	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion	23d. LOCATION CITY OR TOWN COUNTY STATE Lansdowne, MD.		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 7 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other violent cause of death, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carroll C. Wade, Jr.					2a. DATE OF DEATH MONTH DAY YEAR 07 16 87				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 19, 1947		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Facility, Give Street Address Francis Scott Key Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK OR LAST OF WORKING LIFE) Gas Attendant		12b. KIND OF BUSINESS OR INDUSTRY Crown	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4052 St. Monica Dr. 21222	
14. FATHER'S NAME FIRST MIDDLE LAST Carroll C. Wade, Sr.				15. MOTHER'S MAIDEN NAME MIDDLE E. Anderson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 218-48-3593		17. INFORMANT ADDRESS Patricia L. Wade 4052 St. Monica Dr. 21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest + Brain Death</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Cortical Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>underlying cardiac disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7-16-87 7-12-87 Age 17
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Mitral Valve Prolapse</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 12</u> , 19 <u>87</u> , to <u>July 16</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>July 16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen J. Noga</u>				DEGREE <u>MD</u>				22c. DATE SIGNED 7-16-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Noga				22e. ADDRESS 3-127 Oncology Center, 600 N. Wolfe St. Baltimore					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-18-87		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk		24b. ADDRESS 7922 Wise Ave. Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR JUL 17 1987		25b. REGISTRAR'S SIGNATURE Julia Swider-Randall			

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR Film G629 Item 23c, 23d

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20227

1- STATE 7-16-87 SB per FH
REGISTRAR

1. DECEASED NAME (RE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH		DAY		YEAR		2b. HOUR					
GARY		L.		WADE				7		13		19		87		M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male		Black		5/ 18/ 68		19 YRS.						7		13		19		87		11:20 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
Md.				USA								Baltimore City MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore				University Hospital (STU)				MORTON VAN LINES													
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS					
Md.								Baltimore								2533 Francis St. 21217					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																	
Thomas				Vera												Pollard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS													
No				213-80-6767				Vera Wade 2533 Francis St. 21217													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to chest (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?					
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <u>10:26</u> MONTH <u>7</u> DAY <u>13</u> YEAR <u>19 87</u>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <u>Subject was shot.</u>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>alley</u>				21f. LOCATION STREET <u>3000 W. North Ave.,</u> CITY OR TOWN <u>Balto.</u> COUNTY <u></u> STATE <u>MD</u>													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY) <u>Deputy Chief</u>				DATE SIGNED				<u>7-14-87</u>									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
<u>Ann M. Dixon, M.D.</u>				<u>111 Penn St., Balto., MD 21201</u>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (CITY OR TOWN)				STATE					
<u>Burial</u>				<u>7/16/87</u>				<u>Mt. Auburn</u>				<u>Baltimore</u>				<u>MD.</u>					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
<u>Wm. March F/H 1101 E. North Ave.</u>								<u>JUL 15 1987</u>				<u>Julia Davidson-Randall</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20228

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (PLEASE PRINT) Dr. William C. Wade, M.D.			2a. DATE OF DEATH MONTH DAY YEAR July 27, 1987		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 29 15		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dr.-Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY Dundalk	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILL WADE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOTTIE LUCK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 578-18-4109		17. INFORMANT ADDRESS LUCILLE P. WADE 3005 DUNGLAW RD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ischemic Heart Disease</u>					<u>years</u>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic Renal Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11. 24</u> , 19 <u>82</u> , to <u>7. 27</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>7. 24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Bryman</u>		DEGREE MD		22c. DATE SIGNED 7-29-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. W BRYAN		22e. ADDRESS MD GEN HOSP 827 LINDEN AVE BALTIMORE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 7-29-87		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEM.	
23d. LOCATION CITY OR TOWN BALTIMORE.		COUNTY MD		STATE	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 29 1987	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

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ENERGY
WASHINGTON, D.C.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		FIRST		MIDDLE		LAST			
		HOWARD		ARMAND		WAGONHEIM		JULY 23, 1987	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
MALE		CAUCASIAN		DEC. 2, 1926		60 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (IF DECEASED WAS ENGAGED IN LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		2904 TANEY RD., APT. A4B (21209)				MOTION PICTURE EXHIBITOR		MOVIE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MARYLAND				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2904 TANEY RD., APT A4B (21209)	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST		FIRST MIDDLE LAST							
DAVID		WAGONHEIM		ROSE SALEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					
YES		WWII-NAVY		MR. IRA WAGONHEIM					
		215-22-2233		373 GAMBRILLS RD. GAMBRILLS, MD 21054					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus</i>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>July 27, 1987</i> to <i>July 27, 1987</i> , that (1) (we) last saw the deceased alive on <i>July 27, 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.									
23a. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<i>D. B. Posner</i>		<i>MD</i>				<i>7/24/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
DANIEL B POSNER		301 STEAN PL BALTO 21202							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
BURIAL		7/26/87		ARLINGTON CEMETERY		BALTIMORE		MD	
24. FUNERAL DIRECTOR						25a. DATE RECEIVED BY REGISTRAR			
SOL LEVINSON & BROS., INC.						JUL 31 1987			
6010 REISTERSTOWN RD. BALTO, MD 21215						REGISTRAR'S SIGNATURE			
						<i>Sol Levinson</i>			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BESSIE E. WALKER					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 07 14 87 10 ³⁰ AM					
3. SEX F		4. RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR 09 01 09		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD				
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTO. CONFIDENTIAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2711 MURA ST 21213	
14. FATHER'S NAME FIRST MIDDLE LAST WALKER ROBINSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Julia acrey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 225-20-7511		17. INFORMANT Howard F.H		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONTAMINATION SACRAL DECEASE (c) FECAL INCONTINENCE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Bleeding Colostomy										
19a. DATE OF OPERATION 6.24.87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED AND DECEASED CONTAMINATION			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from June 16, 19 87, to July 14, 19 87, that (we) last saw the deceased alive on July 14, 19 87, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (view the body after death).										
22b. SIGNATURE E. Barb J. M.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7.14.87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. BARBERS JR M.						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/18/87		23c. NAME OF CEMETERY OR CREMATORY Zion Poplar Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Gloucester Co., Va.			
24. FUNERAL DIRECTOR NAME Wm C March F/H						25a. DATE REC'D. BY REGISTRAR JUL 16 1987		25b. REGISTRAR'S SIGNATURE Landon Radell		
ADDRESS 1101 E. North Ave.										

BP

022222 JUL 20 01

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "CITY" and "STATE" are faintly visible.]

JUL 20 01

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

060420 JUL 23 1987

FOR
STATE
REGISTRAR

87 REG. NO. 20231

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANTESSA WALKER		2a. DATE OF DEATH MONTH DAY YEAR JULY 16, 1987		2b. HOUR 1:52 a.m.	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 2/13/59		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 28	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO., MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1813 PARK AVE. 21202	
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD WALKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIVIAN GIDDINS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. N/A	17. INFORMANT ADDRESS VIVIAN EVANS 2601 MADISON AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Upper Gastrointestinal bleeding ans septic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophagogastric Candidiasis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetic Ketopacidosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Acute renal failure.</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <u>July 15,</u> 19 <u>87</u> , to <u>July 16,</u> 19 <u>87</u> , that (X) (we) last saw the deceased alive on <u>July 16,</u> 19 <u>87</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Henry Nammour</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-16-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY NAMMOUR		22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/21/87	23c. NAME OF CEMETERY OR CREMATORY EASTVIEW CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD	
24. FUNERAL DIRECTOR NAME Dyett F.H.		ADDRESS 4600 Lib. Rd.		25a. DATE REC'D. BY REGISTRAR JUL 22 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>

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JUL 53 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20232

1. DECEASED NAME (BY OR PRINT) FREDDIE		MIDDLE WALKER		LAST WALKER		2a. DATE OF DEATH MONTH 7 DAY 10 YEAR 87		2b. HOUR M	
3. SEX MALE		4. RACE Black		5. DATE OF BIRTH MONTH 1 DAY 28 YEAR 28		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1315 E. LAFAYETTE AVE.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) General Auto Parts & Supplies			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1315 E. Lafayette Ave. 21213	
14. FATHER'S NAME FIRST Lest MIDDLE Walker LAST Lizzie				15. MOTHER'S MAIDEN NAME FIRST Lizzie MIDDLE Risher LAST Risher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-20-8464		17. INFORMANT ADDRESS Hattie M. Rodd 1315 E. Lafayette Ave. 21213					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA OF THE RECTUM DUE TO, OR AS A CONSEQUENCE OF (c) 4 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6/30 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 600 N. WOLFE ST., 7TH FLOOR		CITY OR TOWN BALTIMORE		COUNTY MD.	
22a. I certify that (I) (this hospital) attended the deceased from 6/30 19 87 , to 7/7 19 87 , that (I) (we) last saw the deceased alive on 7/7 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Peter N. Schlegel				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER N. SCHLEGEL				22e. ADDRESS 600 N. WOLFE ST., 7TH FLOOR, BALTIMORE, MD 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/16/87		23c. NAME OF CEMETERY OR CREMATORY EASTVIEW CEMETARY		23d. LOCATION CITY OR TOWN Baltimore		COUNTY MD.	
24. FUNERAL DIRECTOR NAME WILLIAM C. MARCH FUNERAL HOME				ADDRESS 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR 15 1987			
				25b. REGISTRAR'S SIGNATURE Julia D. Roshan					

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CHRONOLOGICAL INDEX
METASTATIC ADENOCARCINOMA OF
THE RECTUM

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PETER H. SCHNEIDER
JUL 51 82

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059727 JUL 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
FOR Film G629, Item #1, 7/15/87, SB 1- STATE REGISTRAR per FH									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH		2b. HOUR	
Robert Walker			A. H.			DATE MATED <input checked="" type="checkbox"/> 7 10 1987		7 10 1987	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
M	B	1 9 47	40 YRS.	MONTHS	DAYS	7 10 1987		12:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MD		U.S.A.				Baltimore City, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		South Baltimore General Hospital			Unknown				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
MD					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Raleigh			Nannie			Wade			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes			219-52-6404		Nannie Walker 603 Roundview Rd				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stab wound of chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
			1:23 PM 7 9 1987		Subject was stabbed				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		
			Home		2643 Seamon Ave., Baltimore City,		MD.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			
<i>Charles P. Kokes</i>			M.D. Assistant			7-10-87			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS						
Charles P. Kokes, M.D.			111 Penn St., Balto.Md.			21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		7-16-87		Cedar Hill Cemetery		Anne Arundel County Maryland			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
March Funeral Home			1101 E. North Ave.			JUL 14 1987		<i>[Signature]</i>	

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060313 JUL 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20234
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DONALD WALLACE, Jr.			2a. DATE OF DEATH MONTH DAY YEAR JULY 16, 1987		2b. HOUR 3:56P			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04 21 1944		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		
12b. KIND OF BUSINESS OR INDUSTRY Poultry								
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Willards		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Donald Wallace			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Coords					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 082-34-0788		17. INFORMANT Carol Wallace (Wife) Same as #13e				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>s/p Intracranial bleed with clipping of aneurysm.</u>								
19a. DATE OF OPERATION 6-30-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ant. Comm. Aneurysmal bleed			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) N/A				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A				
22a. I certify that (I, (this hospital) attended the deceased from <u>6/29</u> , 19 <u>87</u> , to <u>7/16</u> , 19 <u>87</u> , that (he) (she) (it) saw the deceased alive on <u>7/16</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (do) (did not) view the body after death.								
22b. SIGNATURE <u>Clifford Solomon</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/16/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Clifford Solomon				22e. ADDRESS JHm1 600 N WOLFE ST 21205 Dept Neurosurgery				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 07/20/1987		23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Maryland		
24. FUNERAL DIRECTOR NAME ADDRESS Holloway Funeral Home, P.A., Salisbury, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 21 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Landess		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		3. FIRST		4. MIDDLE		5. LAST	
		Jerome		Walsh					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.	
M		W		4 17 10		77 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. NEVER MARRIED		10. DATE OF DEATH	
Baltimore		U.S.		WIDOWED		DIVORCED		7/ 9/ 19 87	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY		12c. DATE OF DEATH	
Baltimore		1232 N. Calvert St.		21202				7/ 9/ 19 87	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.		BALTO.		BALTO.		YES <input type="checkbox"/> NO <input type="checkbox"/>		1231 N. CALVERT ST.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
				(YES, NO, OR UNKNOWN)		213-28-3054		OFFICER BARTELS, B.P.D. CEN. DIST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
Chronic Obstructive Pulmonary Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							
20. AUTOPSY?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED					
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		STREET, FACTORY, FARM, ETC.)		CITY OR TOWN COUNTY STATE					
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an									
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)						DATE SIGNED	
		Assistant MEDICAL EXAMINER						7/9/87	
EXAMINER'S NAME		ADDRESS							
(TYPE OR PRINT)		Dennis F. Smyth, M.D.						111 Penn St.	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. REGISTRAR'S SIGNATURE	
(SPECIFY)		7-16-87				CITY OR TOWN COUNTY STATE		JUL 22 1987	
REMOVAL								Julia Twicken-Randall	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE	
NAME		ADDRESS							
STATE ANATOMY BOARD		BALTO., MD.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				87 20236	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Niala Sewell Walsh			2a. DATE OF DEATH MONTH DAY YEAR July 11, 1987		1b. HOUR MIN. 11:00 A
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11/03/15		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 524 N. Charles St. 21201		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY ---	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Sewell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Virginia Griffin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A		16b. SOCIAL SECURITY NO. 217-03-3430		17. INFORMANT ADDRESS Mrs. Niala V. Murphy Woodstock, MD 21163	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jeffrey F. Cole, M.D.				22c. DATE SIGNED 7/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeffrey F. Cole, M.D.				22e. ADDRESS 3455 Wilkens Ave. Balto., MD 21229	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/14/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE 14 1987			
24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville, MD					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. (The permittee must remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT! If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ethel K. Walz			2a. DATE OF DEATH MONTH DAY YEAR 7 14 87		2b. HOUR 4:50	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7 27 1898		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 524 North Charles St. 21201		
14. FATHER'S NAME FIRST MIDDLE LAST Otto SCHMIDT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAIMIE HAUG				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-44-0778		17. INFORMANT Rehobeth Beach Del. 19971 Ken Walz 130 Shady Ridge Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute protracted myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Acute coronary artery occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic cardiovascular dis</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 d</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arrhythmia, Congestive heart failure</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> , 19 <u>87</u> , to <u>7/14</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/14</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Ruth Gettes, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/14/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RUTH GETTES, MD				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jul 16 1987		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR JUL 15 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

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STATE OF MARYLAND

FOR by Med. Ex., / Gbj.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 0 0 2 3 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Todd J. Wandenberg		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7/ 22/ 19 87		2b. HOUR M 11:42
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 10-7-86	6. AGE (IN YEARS) MONTHS DAYS 9 15	7. IF UNDER 24 HRS. HOURS MIN. 15
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 405 N. Streeper St.
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INFANT		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO-
14. FATHER'S NAME FIRST MIDDLE LAST BRYNNER WANDEMBERG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARLENA D. PALUGI		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS 21224 Marlena D. Wandenberg - 405 N. Streeper St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration. DUE TO, OR AS A CONSEQUENCE OF (b) Environmental Hyperthermia DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9000
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) exposure to heat
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 405 N. Streeper, Baltimore City, Maryland
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER		DATE SIGNED 7/23/87
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-24-86	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH	
23d. LOCATION CITY OR TOWN BALTO, MD.		23e. COUNTY BALTO		
24. FUNERAL DIRECTOR NAME Walter Miller - 2334 Jefferson St.		25a. DATE REC'D JUL 24 1987		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. RETAIN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMITS AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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061438 JUL 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20239
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANDREW S. WARCHAL			2a. DATE OF DEATH MONTH DAY YEAR JULY 28, 1987		2b. HOUR MIN. 8:25 P		
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 11 17 12		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Litho		12b. KIND OF BUSINESS OR INDUSTRY CONTINENTAL CAN	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST VALENTINE WARCHAL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES OBERG		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE SERVICE AND DATES) YES WW II		16b. SOCIAL SECURITY NO. 157-09-4179	
17. INFORMANT NAME MR. JOSEPH DNHEISER		18. ADDRESS 510 S. MILTON		19. CITY OR TOWN BALTIMORE		20. STATE MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOIA CANCER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JULY 28, 19 87 , to JULY 28, 19 87 , that (I) (we) last saw the deceased alive on JULY 28, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE B. Mapal				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BEENA NAJPAL				22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MD. 21231			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 7-31-87		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem		23d. LOCATION COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME ADDRESS Kaczorowski FUNERAL HOME 2535 Fleet St.				25. DATE REC'D BY REGISTRAR 30 1987			

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial transit permit. Then please remove carbon copy of page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20240

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE KNOWN OF DEATH			21. DATE OF ESTI- MATED			22. DATE OF DEATH			23. DATE OF DEATH			24. HOUR																	
Alverta A. Ward						7-22 1987			7-22 1987			7-22 1987			8:27 A.M.																				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. IF UNDER 1 YR.			8. IF UNDER 24 HRS.			9. BALTIMORE CITY OR COUNTY OF DEATH																	
Female			Black			4-30-52			35 YRS.			MONTHS DAYS HOURS MIN.			Baltimore City																				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY														
Maryland			USA			WIDOWED NEVER MARRIED DIVORCED			Baltimore City			Baltimore			1810 N. Wolfe Street			Disabled																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS					
Maryland						Baltimore			YES NO			1810 N. Wolfe Street			Albert			Anita			No			214-58-8936			Anita Ward			2000 Odell Ave					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART 1 DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF					
Chronic renal failure																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES NO			21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED			21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION			21g. LOCATION					
						YES NO																													
22a. I certify that I took charge of the remains described above, held on			Autopsy			Inspection			Inquiry			and in my opinion			death resulted from:			Natural causes			Accident			Suicide			Homicide			Undetermined manner					
Margarita A. Korell			M.D.			Assistant			MEDICAL EXAMINER			DATE SIGNED			7-22-87																				
EXAMINER'S NAME (TYPE OR PRINT)			Margarita A. Korell, M.D.			ADDRESS			111 Penn St., Balto., MD 21201			23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			23e. DATE REC'D. BY REGISTRAR			23f. REGISTRAR'S SIGNATURE								
Burial			7-28-87			Eastview Mem. Pk.			Baltimore, Maryland			JUL 31 1987			Julia Davidson-Randall																				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION


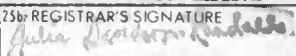
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 20241	
1. DECEASED NAME (TYPE OR PRINT) ALINE WASHINGTON				2a. DATE OF DEATH MONTH DAY YEAR 07 02 87 2b. HOUR 2:47 AM	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 5 8 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1732 N. CAREY ST. 21217	
14. FATHER'S NAME CHARLIE MIDDLE HAWKINS LAST MELON		15. MOTHER'S MAIDEN NAME FIRST MELOAN MIDDLE FOSTER LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT CHART ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (b) CEREBRAL VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF SENILE DEMENTIA (c) SENILE DEMENTIA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/10 85 to 07/02 87 , that (I) (we) saw the deceased alive on 07/02 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Kuang-yen Huang MD		22c. DATE SIGNED 07/02 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG M.D.		22e. ADDRESS BON SECOURS Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-9-87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PK. BALTIMORE COUNTY MARYLAND	
24. FUNERAL DIRECTOR NAME E.L. Phillips ADDRESS 1721-27 N. MONROE ST.		25a. DATE REC'D. BY REGISTRAR JUL 6 1987		25b. REGISTRAR'S SIGNATURE Julia Denson-Randall	

060593 JUL 24 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20242

1. DECEASED NAME (TYPE OR PRINT) CECELIA WASHINGTON			2a. DATE OF DEATH MONTH DAY YEAR 7 18 87		2b. HOUR M
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 5 7 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1100 BOLTON STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1215 W. LANVALE ST.
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW WILLIAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELIA JORDAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Constrictive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Hypertension					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-1 19 82 to 7-18 19 87 , that (I) (we) lost saw the deceased alive on 7-18 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE M		22c. DATE SIGNED 7/24/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M J BROWN		22e. ADDRESS 844 K. Coy. St. - 4117			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 7-23-87		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR NAME ADDRESS E.L. PHILLIPS 1721 N. MONROE STREET		25a. DATE REC'D. BY REGISTRAR JUL 23 1987		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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060761 JUL 27 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20243

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Washington Jr			2a. DATE OF DEATH MONTH DAY YEAR 7 21 87			2b. HOUR 6:15 AM		
3. SEX M	4. RACE B 2	5. DATE OF BIRTH MONTH DAY YEAR 7 8 48			6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.			IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Ctr			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Washington			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Scott			13e. STREET ADDRESS 6317 Brown Ave		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 247 885692		17. INFORMANT Evelyn Washington				
				ADDRESS 6317 Brown Ave				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lymphoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/20</u> 19 <u>87</u> to <u>7/22</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>7/21</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Adelaide S. Robb				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/22/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Adelaide S. Robb				22e. ADDRESS FSK Medical Center			

23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Burial		23b. DATE 7/25/87		23c. NAME OF CEMETERY OR CREMATORY Eastview Mem. Pk.		23d. LOCATION (CITY OR TOWN) COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JUL 24 1987		25b. REGISTRAR'S SIGNATURE Julia Dwyer-Randall	

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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[Faint, mostly illegible text, possibly a letter or report, spanning the main body of the page.]

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 20244
7-23-87 2 AM

1. DECEASED NAME (TYPE OR PRINT) WILLIAM EARL WATERS		2a. DATE OF DEATH MON 7-23-87 HOUR 2 AM	
3. SEX MALE	4. RACE NEGRO	5. DATE OF BIRTH MONTH SEPT DAY 5 YEAR 1929	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS Hosp	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY DISABILITY

13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2864 RAYNET AVE 21216
14. FATHER'S NAME FIRST JENIFER MIDDLE WATERS LAST		15. MOTHER'S MAIDEN NAME FIRST EULALIA MIDDLE CORNNERS LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) KOREAN		16b. SOCIAL SECURITY NO. 220 204415		17. INFORMANT ADDRESS MRS MARION ANNE WATERS 3611 GYMNAST AVE 21207

18. CAUSE OF DEATH (Enter only one cause but list for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Spontaneous pneumo thorax DUE TO OR AS A CONSEQUENCE OF (b) ② severe endstage lung disease DUE TO OR AS A CONSEQUENCE OF (c) disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c) **③ ischemic heart disease**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 7/23/87 to 7/24/87 that (I) (we) last saw the deceased alive on 7/23/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.	
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22b. SIGNATURE <i>[Signature]</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7/24/87
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARCELINO D. ALBUERNE M.D.	22e. ADDRESS 5772 Westview MALL BALTO. MD 21228
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7-27-87	23c. NAME OF CEMETERY OR CREMATORY GARRARD FOREST V.A.	23d. LOCATION CITY OR TOWN BALTO. CO MD COUNTY STATE
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24. FUNERAL DIRECTOR NAME JOSEPH L. RUSS ADDRESS 2222 W. NORTH AVE	25a. DATE REC'D. BY REGISTRAR JUL 27 1987	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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BP

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1. The first part of the report is a description of the project and its objectives. It is followed by a description of the methodology used in the study.

2. The second part of the report is a description of the results of the study. It is followed by a discussion of the implications of the results.

3. The third part of the report is a conclusion and a list of references. It is followed by a list of appendices.

4. The fourth part of the report is a list of references. It is followed by a list of appendices.

5. The fifth part of the report is a list of references. It is followed by a list of appendices.

060272 JUL 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, a traumatic event, the medical examiner must be notified at once.

BP

OHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20245

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Howard S. Watkins</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>7-19-87</i>		2b. HOUR <i>2:30</i> M
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>4-05-1899</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Villa St. Michael</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>	13b. COUNTY <i>--</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>4409 Buchanan Avenue 21211</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Howard Watkins</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Annie McDonald</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) <i>--</i> <i>213-14-8715</i>		17. INFORMANT ADDRESS <i>Kenneth Watkins 4409 Buchanan Avenue 21211</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST - Prob M.I.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Diabetes Type II, Hx AFib</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (this hospital) attended the deceased from <i>Feb 5</i> 19 <i>86</i> to <i>5/18/87</i> 19 <i>87</i> , that (i) (we) saw the deceased alive on <i>5/14/87</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did (did not) view the body after death.					
22b. SIGNATURE <i>Scott Rifkin</i>		DEGREE		22c. DATE SIGNED <i>7/19/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SCOTT RIFKIN</i>		22e. ADDRESS <i>201 E UNIV PKWY</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7/23/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>		23e. DATE REC'D. BY REGISTRAR <i>JUL 21 1987</i>			
24. FUNERAL DIRECTOR NAME <i>A. Alan Seitz, Jr.</i>		ADDRESS <i>3615-19 Chestnut Ave. 21211</i>		24b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Ruback</i>	

080515 JUL 55 BT

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061352 JUL 30 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHREG. NO. 20246
20. DATE OF DEATH MON JUL 24, 19871. DECEASED NAME FIRST MIDDLE LAST
MARGARET GERTRUDE WATTS3. SEX Female 4. RACE Black 5. DATE OF BIRTH MONTH DAY YEAR
Dec. 26, 1903 6. AGE (IN YEARS LAST BIRTHDAY) 83
IF UNDER 1 YEAR IF UNDER 24 HRS
MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD.10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ridgeway Manor 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) Maid 12b. KIND OF BUSINESS OR INDUSTRY
HomesUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD. 13b. COUNTY St. Mary's 13c. CITY OR TOWN Park 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS
Rt. 3, Box 120/2065314. FATHER'S NAME FIRST MIDDLE LAST Tom Washington 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Annie Lawrence16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 217-32-1094 17. INFORMANT ADDRESS
Margaret Butler, same as 13e.18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA
DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.U.D.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) C.V.A.
DUE TO, OR AS A CONSEQUENCE OFPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a
ORGANIC BRAIN SYNDROME19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 6-4, 1987, to 7-24, 1987, that (I) (we) last saw the deceased alive on 7-22, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED
7/24/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 7-28-87 23c. NAME OF CEMETERY OR CREMATORY Immaculate Heart of Mary 23d. LOCATION CITY OR TOWN COUNTY STATE
Lexington Park, St. M., MD.24. FUNERAL DIRECTOR W. Clarke Mattingley, Leonardtown, MD. 25a. DATE RECEIVED BY REGISTRAR JUL 30 1987 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 4 and 5 and file them in the funeral director's office. Page 4 may be retained by the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and dispose of properly. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2. REG. NO. 8 202	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZABETH BESSIE WEAVER		2a. DATE OF DEATH MONTH DAY YEAR July 11 1987 9:15 AM	
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11 02 1906	
6a. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7b. HOUR 9:15 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.	10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL BALTIMORE MD.
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM HOOVER	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE SMITH		16. SOCIAL SECURITY NO. 212-20-3786
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	18. SOCIAL SECURITY NO. 212-20-3786		19. INFORMANT ADDRESS MRS MARGARET JONES 1524 NEIGHBORS AVE 21237
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uroperia DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Alzheimer's Disease			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from June 6, 1987, to July 11, 1987, that (I) (we) lost saw the deceased alive on July 11, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Judith L. Barton M.D.	22c. DATE SIGNED July 11, 1987	22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kaczorowski F. H. 2523 Fleet St.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7-14-87	23c. NAME OF CEMETERY OR CREMATORY SACRED HEART of Jesus	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Kaczorowski F. H.		25. DATE REC'D BY REGISTRAR JUL 14 1987	

X

WILLIAM H. HARRIS
JANUARY 1880
CHICAGO, ILL.

WILLIAM H. HARRIS
JANUARY 1880
CHICAGO, ILL.



WILLIAM H. HARRIS

060270

JUL 22 1987

• FOR •
• STATE •
• DEPARTMENT OF HEALTH AND MENTAL HYGIENE •
• CERTIFICATE OF DEATH •STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20288

1. DECEASED NAME (TYPE OR PRINT) FIRST: Lois MIDDLE: F.D. LAST: Webb			2a. DATE OF DEATH MONTH: 7 DAY: 20 YEAR: 87		2b. HOUR 8:15 AM
3. SEX F	4. RACE C	5. DATE OF BIRTH MONTH: 7 DAY: 31 YEAR: 1900		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Keswick Home 21211		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST: Fred MIDDLE: Hugo LAST: Ford			15. MOTHER'S MAIDEN NAME FIRST: Beryl MIDDLE: Star LAST: Reiny		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 435-22-5950		17. INFORMANT ADDRESS Mrs. Beryl Davis 830 W. 40th Street 21211	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>senility</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19_____, to 7-20, 1987, that (I) (we) last saw the deceased alive on 7-19, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE S. H. Wilson Jr. M.D.				22c. DATE SIGNED 7-20-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilson, Jr.				22e. ADDRESS 700 West 40th Street 21211	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/23/87	23c. NAME OF CEMETERY OR CREMATORY Lake Lawn Park		23d. LOCATION CITY OR TOWN COUNTY STATE New Orleans Louisiana
24. FUNERAL DIRECTOR NAME ADDRESS A. Alan Seitz, Jr. 3818 Roland Ave. 21211				25a. DATE REC'D. BY REGISTRAR JUL 21 1987	
25b. REGISTRAR'S SIGNATURE Julia Twicken-Pendley					

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, Bureau of Vital Records, Baltimore, Maryland.

BP

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061517 AUG -4 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20249

1. DECEASED NAME (TYPE OR PRINT) Pinkie (Pink) Webb			2a. DATE OF DEATH MONTH DAY YEAR 7-31-87		2b. HOUR 8 A M		
3. SEX F		4. RACE B 2		5. DATE OF BIRTH MONTH DAY YEAR 7-02-1885		6. AGE (IN YEARS LAST BIRTHDAY) 102 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Ben Secours Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Fed Webb		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Moore		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-54-0086	
17. INFORMANT Ennell L. Webb		ADDRESS 2213 W. Baltimore St		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Electrolyte imbalance, Pre-renal azotemia & dehydration							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE OF DEATH MONTH DAY YEAR 7/31 87	
22a. I certify that (I) (this hospital) attended the deceased from 7/31 19 87 , to 7/31 19 87 , that (I) (we) last saw the deceased alive on 7/31 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Juan A. Beltran		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN A. BELTRAN		22e. ADDRESS 1940 W. BALTIMORE ST 21223					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/3/87		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. c. March F/H West 4300 Wabash Avenue				25a. DATE REC'D. BY REGISTRAR AUG 3 1987		25b. REGISTRAR'S SIGNATURE Lelia Tisdler-Rudolf	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pen. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. DECEASED NAME (TYPE OR PRINT) George Adalbert Weber					2a. DATE OF DEATH MONTH DAY YEAR July 12th, 1987					2b. HOUR 1:20 p.m.		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 14, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 90 years YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 705 S. Ann Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mortician			12b. KIND OF BUSINESS OR INDUSTRY Funeral			
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 705 S. Ann Street #21231	
14. FATHER'S NAME FIRST MIDDLE LAST John Weber					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Constance Nowak							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF NOT IN SUCH FACILITY, GIVE WAR OR DATES) 212-36-6244		17. INFORMANT ADDRESS Thaddeus M. Weber-6845 Duluth Ave. #21222								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Atrial Fibrillation</i>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 19 86</i> , to <i>7-12 19 87</i> , that (I) was lost saw the deceased alive on <i>7-3 19 87</i> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was <i>did</i> (did not) view the body after death.												
22b. SIGNATURE <i>Marion C. Kowalewski M.D.</i>					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-13-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marion C. Kowalewski M.D.					22e. ADDRESS 8604 Harford Road #21234							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Md.				
24. FUNERAL DIRECTOR NAME George A. Weber & Sons, Inc.-705 S. Ann St.					25a. DIRECTOR'S SIGNATURE JUL 14 1987							

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OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20251

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE KNOWN OF DEATH ESTI- MATED			MONTH DAY YEAR			2b HOUR							
Roland			H.			Weber			7-28-87			M							
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d HOUR			
Male		White		Dec. 28, 1922		64 YRS.		MONTHS DAYS		HOURS MIN.		7-28-87		10:35		a			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				USA								Baltimore City MD							
10 CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FORM MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore				1626 Jackson Street Balto. Md.				Ret. Fireman				Balto. City 21230							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland				Baltimore				YES <input type="checkbox"/> NO <input type="checkbox"/>				1626 Jackson St. Balto. Md.							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
William J. Weber				Marion Creighton															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
No				214-16-5486				Marjorie J. Weber				Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) disease and status post right pneumonectomy																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from a Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Mario F. Golle, Jr., M.D.				Assistant MEDICAL EXAMINER				7-29-87											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Mario F. Golle, Jr., M.D.				111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				7/31/1987				Cedar Hill Cemetery				Balto. A.A. Co. Maryland							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
McCully Funeral Home				Balto. Md. 21230 Ave. 130 E. Fort				AUG 4 1987				Julia Davidson-Randall							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / REG. NO. 20252

1. DECEASED NAME (TYPE OR PRINT) SIGNE S WEBSTER			2a. DATE OF DEATH MONTH DAY YEAR 7 23 87			2b. HOUR 545 AM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 15 05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NY		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Maryland Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY Wicomico		13c. CITY OR TOWN Mardela Springs		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST August Isberg			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Hanssan			13e. STREET ADDRESS / ZIP CODE Rt 1, Box 746 F 21837				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 2M-74-3466		17. INFORMANT Hospital Chart				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Pulmonary Standstill DUE TO, OR AS A CONSEQUENCE OF (b) Multi-system failure DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Intracranial Hemorrhage										
19a. DATE OF OPERATION 7/15/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intracranial Hemorrhage			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (a) (this hospital) attended the deceased from 7/23 19 87 to 7/23 19 87 , that (b) (we) last saw the deceased alive on 7/23 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Charles Cheng DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES CHENG MD						22e. ADDRESS Univ of Maryland Hospital 800 S. Greene St. Balto MD 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/25/87		23c. NAME OF CEMETERY OR CREMATORY Webster-Brizle Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Princess Anne Somerset MD		
24. FUNERAL DIRECTOR James H. Hanner Jr. 1000 E. Pennsylvania Ave. Md.						25a. DATE REC'D BY REGISTRAR JUL 28 1987				
25b. REGISTRAR'S SIGNATURE John Darden-Rodgers										

BP _____

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(VRS 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. Please do not mutilate, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

UNITED STATES DEPARTMENT OF AGRICULTURE
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WASHINGTON, D. C.

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WASHINGTON, D. C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20253
REG. NO.

1 - STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
SUSAN Naomi WEHNER		JULY 3, 1987		9:50 PM	
3 SEX	4. RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	7 MONTH 14 DAY 20 YEAR	66 YRS.	IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		BALITMORE CITY MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY
BALTIMORE	THE JOHNS HOPKINS HOSPITAL		Retired		Housework
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?		
Md.		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Gustave Meurer		Elizabeth			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
No		220-01-7420		Susan Parker 12 Wilbur Rd. 21221	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) ACUTE Renal failure					3 months
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension Hypertension					10 years
DUE TO, OR AS A CONSEQUENCE OF (c) Peripheral vascular disease					40 years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
Congestive Heart failure					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (s) (this hospital) attended the deceased from 8/27 1987 to 7/3 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)					

MEDICAL CERTIFICATION

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Paul J. Scheer, Jr. MD

22e. ADDRESS

The Johns Hopkins Hosp 600 N WOLFE ST 21205

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

7-7-87

23c. NAME OF CEMETERY OR CREMATORY

Sacred Heart of Jesus

23d. LOCATION

Dundalk Balto. Co., Md.

24 FUNERAL DIRECTOR

Charles S. Zeiler & Son Inc. 6224 Eastern Ave.

25a. DATE RECD. BY REGISTRAR

JUL 07 1987

25b. REGISTRAR'S SIGNATURE

Julia Gordon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20254

1. DECEASED NAME (LAST, FIRST, OR PRINT) WILLIAM JOSEPH WEIMAN			2a. DATE OF DEATH MONTH DAY YEAR 07 13 87		2b. HOUR 7 ³⁰ PM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8 29 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.		
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTO GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY Furniture Co.	
13a. STATE Maryland		13b. COUNTY A.A.	13c. CITY OR TOWN Glen burnie	13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 110 Warwickshire Lane Apt. M 21061
14. FATHER'S NAME FIRST MIDDLE LAST JOHN WEIMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA EVERETT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-01-1654		17. INFORMANT ADDRESS Apt. M 21061 Joseph V. Weiman 110 Warwickshire Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>END STAGE COPD</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>MULTIFOCAL ATRIAL TACHYCARDIA</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he) (this hospital) attended the deceased from <u>July 2</u> 19 <u>87</u> , to <u>July 13</u> 19 <u>87</u> , that (we) last saw the deceased alive on <u>July 13</u> 19 <u>87</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>P. Barber Jr</u>				22c. DATE SIGNED 7.13.87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. BARBER JR MD				22e. ADDRESS South Baltimore Gen. Hosp.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/16/87	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR JUL 16 1987		
			25b. REGISTRAR'S SIGNATURE <u>Julia Sinden-Randall</u>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20255

1. DECEASED NAME (TYPE OR PRINT) FIRST: <u>Helen</u> MIDDLE: <u>Weinberg</u> LAST: <u>Weinberg</u>			2a. DATE OF DEATH MONTH: <u>7</u> DAY: <u>27</u> YEAR: <u>87</u>		2b. HOUR <u>1A</u> M							
3 SEX <u>FEMALE</u>		4 RACE <u>W</u> HITE		5. DATE OF BIRTH MONTH: <u>9</u> DAY: <u>9</u> YEAR: <u>07</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS		IF UNDER 1 YEAR MONTHS: _____ DAYS: _____		IF UNDER 24 HRS HOURS: _____ MIN: _____		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Balto Md</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Balto City</u> MD						
10. CITY OR TOWN OF DEATH <u>BALTIMORE</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Levinvale</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Secretary</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>RESISTO TIE COMPANY</u>				
13a. STATE <u>Md</u>			13b. COUNTY <u>Balto</u>		13c. CITY OR TOWN <u>Balto</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>2500 W. Belvedere</u> <u>Apt 41521215</u>			
14. FATHER'S NAME FIRST: <u>HARRY</u> MIDDLE: _____ LAST: <u>WEINBERG</u>			15. MOTHER'S MAIDEN NAME FIRST: <u>LEAH</u> MIDDLE: _____ LAST: <u>UNKNOWN</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>212-03-3374</u>			
17. INFORMANT <u>RON WEINBERG</u>			ADDRESS <u>2409 FOREST GREEN RD.</u>			21209						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION <u>7/27</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>COPI</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from <u>7/27</u> 19 <u>87</u> to <u>7/27</u> 19 <u>87</u> , that (we) last saw the deceased alive on <u>7/27</u> 19 <u>87</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Estrelita Ku</u>						DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>7/27/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ESTRELITA KU</u>						22e. ADDRESS <u>HEBREW YOUNG MEN CEM BALTIMORE MD</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>7/28/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HEBREW YOUNG MEN CEM BALTIMORE</u>		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., INC.</u> <u>6010 REISTERSTOWN RD. BALTO, MD 21215</u>						25a. DATE REC'D. BY REGISTRAR <u>JUL 31 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Tindall-Rudolph</u>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

WEINBERG, HELEN

LEVINVALLE

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the date of death be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit permit. Then please move to non-appeal pages. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. AIR FORCE

OFFICE OF THE SECRETARY

WASHINGTON, D.C.

JUL 21 1981

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 / 20256
REG. NO.

060702 JUL 27 1987

1. DECEASED NAME (TYPE OR PRINT) MATILDA K. WEINER			2a. DATE OF DEATH MONTH DAY YEAR JULY 19, 1987		2b. HOUR 10:45PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB. 11, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2245 ROGENE DR. APT. 101 (21209)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2245 ROGENE DR. APT. 101 (21209)	
14. FATHER'S NAME FIRST MIDDLE LAST MYER KARLINSKY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE KABICK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-54-2486A	17. INFORMANT ADDRESS ARNOLD M. WEINER 8201 SPRING BOTTOM WAY (21208)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive Terminal Ovarian Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from Aug - 19 87 to July 19 87 , that (I) (we) last saw the deceased alive on July 6 87 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kenneth J. Glick DEGREE				22c. DATE SIGNED 7/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENNETH GLICK				22e. ADDRESS 10219 S. DOLFIELD RD. OWINGS MILLS, MD. (21117)	
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) BURIAL	23b. DATE 7/21/87	23c. NAME OF CEMETERY OR CREMATORY BETH EL MEM. PARK	23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN, BALTO, MD.		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD. (21215)			25a. DATE REC'D. BY REGISTRAR JUL 24 1987	25b. REGISTRAR'S SIGNATURE Julia Darden-Rodman	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. The placid must have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20251

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gertrude S. Wells		2a. DATE OF DEATH MONTH DAY YEAR 7 23 87		2b. HOUR 1:03am	
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 12 22 95		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marsha Williams		13e. STREET ADDRESS / ZIP CODE 2524 W. Fayette Street 21223	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-28-4369		17. INFORMANT ADDRESS Mr. Joseph Wells 4600 Norfolk Ave. 21216	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration/Mal Nutrition DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Alzheimer's Disease DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/22/87 to 7/23/87, that (I) (we) last saw the deceased alive on 7/22/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE Theo C Patterson		DEGREE MD		22c. DATE SIGNED 7/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THEO C PATTERSON		22e. ADDRESS 1576 Merritt Ave Dun. Md 21222			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-27-87	23c. NAME OF CEMETERY OR CREMATORY ARBUS MEm PK		23d. LOCATION Bkto Cd Md	
24. FUNERAL DIRECTOR NAME Joseph L. Russ		ADDRESS 2222 W. NORTH AVE		25a. DATE REC'D. BY REGISTRAR JUL 27 1987	
		25b. REGISTRAR'S SIGNATURE			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 REG. NO. 2 0 2 5 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Bernard J. Wenker, Sr.			2a. DATE OF DEATH MONTH DAY YEAR 7- 25- 87		2b. HOUR 1:45 ^P _M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1- 27- 23 ^R	6. AGE (IN YEARS LAST BIRTHDAY) 64	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7c. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3524 Chesterfield Ave. 21213		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Set-Up Oper.	12b. KIND OF BUSINESS OR INDUSTRY A.T.T.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY —	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Frederick G. Wenker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Dreger		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II	17. INFORMANT ADDRESS Margaret Wenker 3524 Chesterfield Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma of</u> DUE TO, OR AS A CONSEQUENCE OF <u>Right colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (as a hospital) attended the deceased from <u>11/5</u> , 19 <u>87</u> , to <u>7/25</u> , 19 <u>87</u> , that (I) (as a) last saw the deceased alive on <u>7/23</u> , 19 <u>87</u> , and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.					
22b. SIGNATURE <u>John W. Bowie MD</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7/27/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John W. Bowie			22e. ADDRESS 500 W. University Pkwy. Apt. 1 N		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-29-87	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME 3331 Brehms Lane Balto., Md. Schimunek Funeral Home, Inc. 21213			25. DATE REC'D. BY REGISTRAR JUL 27 1987		
			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by letter.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20259

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REBA WETHERILL			2a. DATE OF DEATH MONTH DAY YEAR JULY 4, 1987		2b. HOUR 7:15 AM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 29, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LATVIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3601 FORDS LANE APT. 607 (21215)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3601 FORDS LANE APT. 607 (21215)	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY JACOBS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE LEVINSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-34-0305		17. INFORMANT ADDRESS LOUIS COLEMAN 2508 GUILFORD AVE. 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Artd DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Artd DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-18, 1980 , to 7/9, 1987 , that (I) (we) last saw the deceased alive on 5/29, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE ARTHUR LEBSON				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR LEBSON				22e. ADDRESS 3640 FORDS LANE BALTO., MD. (21215)					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/6/87		23c. NAME OF CEMETERY OR CREMATORY ANSHE EMUNAH AITZ CHAIM CEM-BALTIMORE		23d. LOCATION CITY OR TOWN COUNTY STATE MD		23e. DATE REC'D. BY REGISTRAR JUL 08 1987	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS.				24b. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)		25b. REGISTRAR'S SIGNATURE Julia Swinson-Randall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FRANCIS		FIRST —		MIDDLE —		LAST WHEELER		2a. DATE OF DEATH MONTH DAY YEAR 7 18 87		2b. HOUR 0745 M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 21 06		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Baltimore County Schools		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.		13b. COUNTY —		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 805 Wellington St. 21211			
14. FATHER'S NAME FIRST — MIDDLE — LAST unknown				15. MOTHER'S MAIDEN NAME FIRST — MIDDLE — LAST unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-01-6466		17. INFORMANT Baltimore, MD		ADDRESS 21211		Mrs. Kathleen Jackson 805 Wellington St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PNEUMONIA. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-5 Days 5-10 Days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive Pulmonary Disease.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7/11/87 , 19 87 , to 7/18 , 19 87 , that (I) (we) last saw the deceased alive on 7/18 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Kenneth Russ		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/18/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth Russ				22e. ADDRESS 1806 Thomas Street Apt 22 Balto, MD 21231							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7-20-87		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore MD					
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc ADDRESS 8728 Liberty Rd. Randallstown, MD 21133				25a. DATE REC'D. BY REGISTRAR JUL 22 1987		25b. REGISTRAR'S SIGNATURE John D. ...					

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 REG. NO. 20261
7 15 87 845 M
DATE OF DEATH MONTH DAY YEAR 2b HOUR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLOTTE E. WHEELLEY		2a. DATE OF DEATH MONTH DAY YEAR 7 15 87		2b. HOUR 845 M	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12 30 02		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deaton South Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Halethorpe	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1802 Palo Circle 21227	
14. FATHER'S NAME FIRST MIDDLE LAST John Hauenstein		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie McDonald			
16a. WAS DECEASED IN U.S. ARMED FORCES? (YES, NO <input checked="" type="checkbox"/> IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-01-3563		17. INFORMANT ADDRESS Lester E. Wheelley 1802 Palo Circle 21227	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio Respiratory Arrest.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 18, 1987, to July 15, 1987, that (I) (we) last saw the deceased alive on July 15, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE John A. Tygant MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 7/15/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Tygant		22e. ADDRESS 3001 S. Harove St. Galt MD 21220	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/18/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25a. DATE RECD. BY REGISTRAR JUL 17 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.


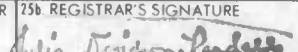
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

06 00 58 JUL 51

NOTES TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE PAGES. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRINCESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR 2- REG. NO. 262									
3. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David W. Whitby									
4. SEX Male		5. RACE White		6. DATE OF BIRTH (MONTH DAY YEAR) July 14, 1954		7. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 32 YRS.		8. DATE OF DEATH (MONTH DAY YEAR) HOUR 7-4 1987	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Shady Side Md		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		13. DATE PRONOUNCED DEAD (MONTH DAY YEAR) HOUR 7-4 1987 6:14 A.M.	
14. CITY OR TOWN OF DEATH Baltimore		15. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 200 Block E. 28th St. at Guilford Ave.				16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 21218		17. KIND OF BUSINESS OR INDUSTRY	
18. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2800 Guilford Ave.	
19. FATHER'S NAME FIRST MIDDLE LAST Albert Wallace Whitby Sr		20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rita King		21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		22. SOCIAL SECURITY NO. 212-60-1055		23. INFORMANT ADDRESS #14-1314 Pine St; Shady Side, Md. 20754	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt force head trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.									
25. DATE OF OPERATION		26. CONDITION FOR WHICH OPERATION WAS PERFORMED?						27. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
28. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2 P.M. 7-4-1987		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject beaten					
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		33. LOCATION STREET CITY OR TOWN COUNTY STATE 200 Block E. 28th St. at Guilford Ave., Baltimore City, MD		34. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
35. ACTUAL SIGNATURE 		36. EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		37. TITLE (SPECIFY) M.D. Deputy Chief		38. DATE SIGNED 7-4-87		39. ADDRESS 111 Penn St., Baltimore, MD 21201	
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		41. DATE 7-8-87		42. NAME OF CEMETERY OR CREMATORY Woodfield		43. LOCATION CITY OR TOWN COUNTY STATE Galesville AACo Md		44. FUNERAL DIRECTOR NAME ADDRESS Hardesty FH, 12 Ridgely Ave, Annapolis, Md. 21401	
45. DATE REC'D. BY REGISTRAR JUL 07 1987		46. REGISTRAR'S SIGNATURE 							

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20263

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERALD LEE WHITE			2a. DATE OF DEATH MONTH DAY YEAR JULY 29, 1987		2b. HOUR 3:50 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9/26/1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant Seaman Dis.		12b. KIND OF BUSINESS OR INDUSTRY Md. 21225
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 920 E. Patapsco Ave. Balto. Md. 21225
14. FATHER'S NAME FIRST MIDDLE LAST Forrest ---- White			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva ---- Gardner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 249-22-4948		17. INFORMANT ADDRESS Evelyn M. White, Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 911 DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) aspiration of vomit APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mins 2 mins 15 minutes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Metastatic colon CA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/29/87 19, to 7/29/87 19, that (I) (we) last saw the deceased alive on 7/29/87 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mark Hargan				22c. DATE SIGNED 7/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark Hargan				22e. ADDRESS Johns Hopkins University	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/ 87		23c. NAME OF CEMETERY OR CREMATORY Shilow Meth. Church	
23d. LOCATION CITY OR TOWN COUNTY STATE Chester Shilow Co. S.C.		23e. NAME OF CEMETERY OR CREMATORY Cent.		23f. LOCATION CITY OR TOWN COUNTY STATE Chester Shilow Co. S.C.	
24. FUNERAL DIRECTOR NAME McCully Funeral Home,		24b. ADDRESS 237 E. Patapsco Ave, Balto. Md. 21225		25a. DATE REC'D. BY REGISTRAR AUG 4 1987	
25b. REGISTRAR'S SIGNATURE Julia Jr					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please prepare carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must have the certificate of autopsy.

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WNC-295 081544

061579 AUG 4 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20264

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAROLD WHITE			2a. DATE OF DEATH MONTH DAY YEAR 7/26/87		2b. HOUR 3 20 M
3. SEX M	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 12 1917		6. AGE (IN YEARS (LAST BIRTHDAY)) 70 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERCY HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD	13c. COUNTY Balto	13d. CITY OR TOWN Balto	13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13f. STREET ADDRESS / ZIP CODE 320 GRANTLEY ST BALT MD 21224	
14. FATHER'S NAME FIRST MIDDLE LAST Albert White	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Conyers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) NO	16b. SOCIAL SECURITY NO. 247 26 7316	17. INFORMANT NAME ADDRESS W. Woods 320 GRANTLEY ST BALT MD 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unhappy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>depression</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>possible other illness</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/24</u> , 19 <u>87</u> , to <u>7/26</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>7/25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ret. Peter Chen		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER CHEN		22e. ADDRESS 14711 VALIANT TOWN BURTONSVILLE MD 20864			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/31/87	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue		25. RECEIVED BY REGISTRAR JUL 31 1987 25b. REGISTRAR'S SIGNATURE			

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061230 WDC-481

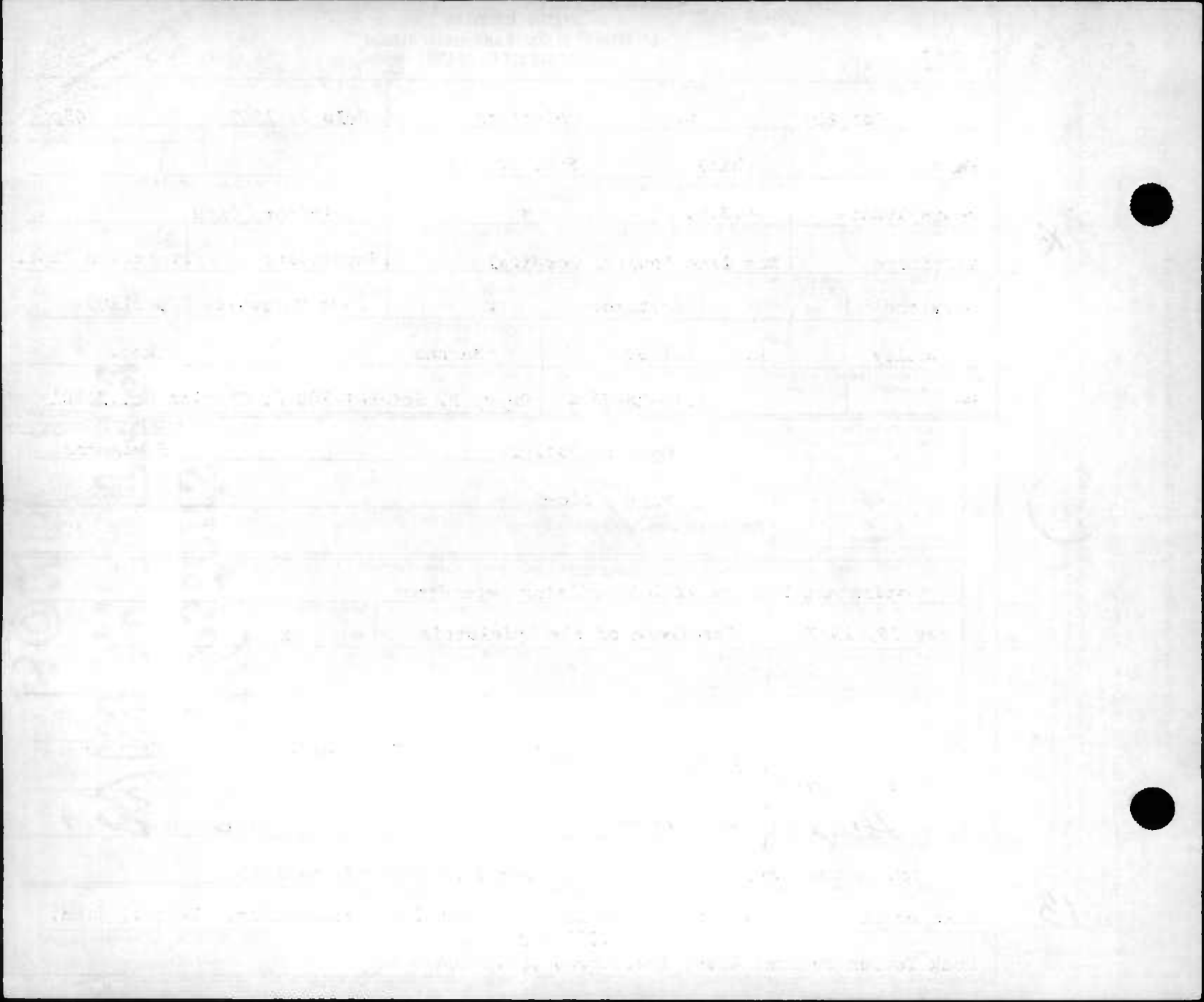
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert in this paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified by phone.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1. STATE
REGISTRAR

REC'D NO.

20265

1. DECEASED NAME (TYPE OR PRINT) Dorothy K. Whiteford			2a. DATE OF DEATH MONTH DAY YEAR July 5, 1987		2b. HOUR 6:45p M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 18, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Probation Dept.
13a. STATE Maryland		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2804 Cheswolde Rd. 21209
14. FATHER'S NAME FIRST MIDDLE LAST Wesley H. Kelley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-28-5684		17. INFORMANT ADDRESS Henry F. Stickel-100 S. Charles St., 21201	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septic Shock DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Respiratory Failure with Ventilator Dependence					
19a. DATE OF OPERATION May 18, 1987		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the Epiglottis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from May 17, 1987, to July 5, 1987, that (we) last saw the deceased alive on July 5, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (I) (did) (do) not view the body after death.					
22b. SIGNATURE Howard Kane MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Howard Kane		22e. ADDRESS Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 7-9-87	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Mausoleum		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto., Md.
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc., Towson, Md. 21204		ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

098038 JUL 1

Item #7a G 629 7/10/87 cw

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- STATE REGISTRAR Alexander Whitney Sr.

20260

1. DECEASED NAME (TYPE OR PRINT) ALEXANDER

2a. DATE OF DEATH MONTH 7 DAY 4 YEAR 87 2b. HOUR 6:47 AM

3. SEX M Male 4. RACE W White 5. DATE OF BIRTH MONTH 12 DAY 7 YEAR 1902

6. AGE (IN YEARS (LAST BIRTHDAY)) 84 YRS 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York 8. MARried NEVER MARried WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD. 10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrical Engineer 12b. KIND OF BUSINESS OR INDUSTRY Westinghouse

13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN CATONSVILLE 13d. INSIDE CITY LIMITS? YES NO X

13e. STREET ADDRESS / ZIP CODE 711 MAIDEN CHOICE LANE 21228 14. FATHER'S NAME FIRST MIDDLE LAST EDDY R. WHITNEY

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAY PEASE 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 179-01-6292

17. INFORMANT ALEXANDER WHITNEY ADDRESS 3676 MEADOWVALE ROAD ELICOTT CITY, MD. 21043

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA (c) DUE TO, OR AS A CONSEQUENCE OF

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: INFLAMMATORY BOWEL DISEASE

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES NO X 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) 21f. LOCATION CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from JUNE 29 19 87 to JULY 4 19 87 that (I) (we) lost saw the deceased alive on JULY 4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE RESIDENT ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) BOON P. LIM 22e. ADDRESS ST. AGNES HOSPITAL, Baltimore, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 7/7/87 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md. 24. FUNERAL DIRECTOR NAME 1630 Edmondson Ave. Catonsville, Md. 21228

25a. DATE REC'D. BY REGISTRAR JUL 7 1987 25b. REGISTRAR'S SIGNATURE Julia Benson-Randall

25c. REGISTRAR'S SIGNATURE

25d. REGISTRAR'S SIGNATURE

25e. REGISTRAR'S SIGNATURE

25f. REGISTRAR'S SIGNATURE

25g. REGISTRAR'S SIGNATURE

25h. REGISTRAR'S SIGNATURE

25i. REGISTRAR'S SIGNATURE

25j. REGISTRAR'S SIGNATURE

25k. REGISTRAR'S SIGNATURE

25l. REGISTRAR'S SIGNATURE

25m. REGISTRAR'S SIGNATURE

25n. REGISTRAR'S SIGNATURE

25o. REGISTRAR'S SIGNATURE

25p. REGISTRAR'S SIGNATURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

ATTENTION FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove subsequent papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CARL		WHITTED						07 02 87		3:55P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
MALE		BLACK		9/18/28		58					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
DURHAM, N.C.		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON		6701 N. CHARLES STREET G.B.M.C.				BALTO. CITY		RECREATION			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13f. STREET ADDRESS / ZIP CODE	
MD.		ELKRIDGE								2006 NORTHEAST AVE. 21227	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
NORFLEY WHITTED		AUDREY DIXON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES		WWII		239-40-2709		BARBARA WHITTED		2006 NORTHEAST AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF LUNG, METASTATIC TO LIVER</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/22</u> , 19 <u>87</u> , to <u>7/02</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>7/02</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>John C. Pestaner</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>7/2/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN C. PESTANER				22e. ADDRESS G.B.M.C., 6701 N. CHARLES STREET, 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/7/87		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILL, MARYLAND					
24. FUNERAL DIRECTOR NAME LEROY O. DYETT				ADDRESS 4500 LIBERTY HEIGHTS		25a. DATE REC'D. BY REGISTRAR JUL 03 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Kendall</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The detached portion contains certain placards. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as a duty.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20268

1. DECEASED NAME (TYPE OR PRINT) HARRY Gustaf Wianke Sr			2a. DATE OF DEATH MONTH DAY YEAR 07 03 87			2b. HOUR 9 10 AM					
3. SEX M Male		4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR 08 07 05		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Med Ctr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker.		12b. KIND OF BUSINESS OR INDUSTRY Makers & Cabinet Joiners			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 131 Ventnor Terr./21222		
14. FATHER'S NAME FIRST MIDDLE LAST Paul Wianke				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Baginski							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 216-03-1600		17. INFORMANT ADDRESS Harry G. Wianke, Jr. (same as 13e.)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> , 19 <u>87</u> , to <u>7/3</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/3</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE F. M. Mahon MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/3/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANCIS McMAHON						22e. ADDRESS Francis Scott Key Med Ctr					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/8/1987		23c. NAME OF CEMETERY OR CREMATORY Lorraine Pk. Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS Walter Brooks Bradley, Inc, Balto., Md. 21222						25a. DATE REC'D. BY REGISTRAR JUL 6 1987		25b. REGISTRAR'S SIGNATURE Julia Swinson-Randall			

MEDICAL CERTIFICATION

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JUL 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20269

1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN H WIGGINS			2a. DATE OF DEATH MONTH DAY YEAR 7 14 87		2b. HOUR 9:25 PM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 26 16	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hosp. Balto.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer	12b. KIND OF BUSINESS OR INDUSTRY BOARD OF EDUGA	
13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST HERMAN WIGGINS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TLER B SELPH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-09-9042	17. INFORMANT ER-REG		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) infra-cranial bleed Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) sepsis of unknown etiology					
19a. DATE OF OPERATION 2		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) PATIENT FELL WHILE WALKING	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) AT HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1119 ELLICOTT DR BALTIMORE MD	
22a. I certify that (I) (this hospital) attended the deceased from July 9, 19 87, to July 14, 19 87, that (I) (we) last saw the deceased alive on July 14, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael K. Sauter			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/14/87
22a. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL K. SAUTER			22e. ADDRESS University of Maryland Hosp, 2250 GREEK ST.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/19/87	23c. NAME OF CEMETERY OR CREMATORY Selph Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Whitestone Va.	25a. DATE REC'D. BY REGISTRAR JUL 17 1987	
24. FUNERAL DIRECTOR NAME William C. Brown			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

022222 JUL 50 61

[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page. Some words like "JUL 50 61" and "022222" are visible.]

61458 JUL 30 1987 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20270

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BRANDON M WILDER.			2a. DATE OF DEATH MONTH DAY YEAR 07 25 87		2b. HOUR 3:57 AM
3. SEX MALE	4. RACE BLACK.	5. DATE OF BIRTH MONTH DAY YEAR 05 23 85		6. AGE (IN YEARS LAST BIRTHDAY) 2 YRS 2 Mon. YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A.
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 813 DARTMOUTH RD. 21212
14. FATHER'S NAME FIRST MIDDLE LAST SCOTT WILDER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PAULA SANDERS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 219-0820942		17. INFORMANT ADDRESS Paula Sander 813 Dartmouth Rd. Apt. C (12)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO - RESPIRATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) COMPLEX CONGENITAL HEART DISEASE. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — —	
22a. I certify that (I) (this hospital) attended the deceased from 7/24 19 87 to 7/25 19 — , that (I) (we) last saw the deceased alive on 7/24 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rajani Anand.				22c. DATE SIGNED 7/25/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAJANI ANAND.				22e. ADDRESS 22 S. GREENE ST. UNIVERSITY OF MD. HOSPITAL, MARYLAND.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/28/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Chas. A. Rice FSPA 1300 Eutaw place			25. DATE REC'D. BY REGISTRAR JUL 31 1987		
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

81428 JUL 30 81

JUL 31 1981

060424 JUL 23 07

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20271

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruie Wilkins			2a. DATE OF DEATH MONTH DAY YEAR 7 19 1987		2b. HOUR M 1						
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 6 7 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS 0 0		IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md						13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ephram Wilkins						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Della Wilkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-05-2671		17. INFORMANT Leroy Wilkins				ADDRESS 3907 Mondawmin Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MYOCARDIAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (b) ASCUD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1984 July 1984			22a. DATE SIGNED		
22a. I certify that (I) (this hospital) attended the deceased from April 28 19 84 , to July 19 84 , that (I) (we) lost saw the deceased alive on 7-18 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard M. Hewitt						DEGREE M.D.			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard M. Hewitt						22e. ADDRESS West 4300 Wabash Avenue					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/23/87		23c. NAME OF CEMETERY OR CREMATORY Western Star Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Md		23e. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H						25a. DATE REC'D. BY REGISTRAR JUL 22 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to the interment, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ACUTE MYOCARDIAL INFARCT
ASCENDING

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20272

1. STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
BABY BOY		JULY 2, 1987		12:30 A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	BLACK	MONTH DAY YEAR	YRS	MONTHS DAYS	IF UNDER 24 HRS
		07-02-87			HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
BALTIMORE	THE JOHNS HOPKINS HOSPITAL				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
MARYLAND			BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	120 N. COLLINGTON. 21231
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
EARL PARKER		VERONICA WILLIAMS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				VERONICA WILLIAMS (SAME)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Prematurity, Non-Viable Fetus					10 minutes
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 2, 19 87, to July 3, 19 87, that (I) (we) last saw the deceased alive on July 2, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Ada Hamosh MD				7/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Ada Hamosh				Johns Hopkins Hospital, 600 N. Wolfe St. Balto MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE	
CREMATION		7/2/87	JOHNS HOPKINS HOSP BALTIMORE	21205 Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
				JUL 29 1987 Julia Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

081385 JUL 30 85

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20273
DATE OF DEATH MONTH 7 DAY 12 YEAR 87 HOUR 1:40 P.M.

1. DECEASED NAME (TYPE OR PRINT) FIRST Alex MIDDLE Wright LAST Williams ALEX WRIGHT WILLIAMS		2a. DATE OF DEATH MONTH 7 DAY 12 YEAR 87 HOUR 1:40 P.M.	
3. SEX Male MALE	4. RACE Caucasian White	5. DATE OF BIRTH MONTH 05 DAY 02 YEAR 38	6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore CITY MD
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST Agnes Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LPN	12b. KIND OF BUSINESS OR INDUSTRY Nursing
13a. STATE MD		13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore
14. FATHER'S NAME FIRST Alex MIDDLE Williams		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE A. LAST Faircloth	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes Korean		16b. SOCIAL SECURITY NO. 237-56-7745	
17. INFORMANT Mrs. Cynthia M. Williams		ADDRESS Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Brain stem herniation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic Colonic CA + obstruction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a <u>Cardiopulmonary Arrest</u>			
19a. DATE OF OPERATION 7/2/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED metastatic Colonic CA with small bowel obstruction	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/25 19 87 to 7/12 19 86, that (I) (we) last saw the deceased alive on 7/12 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>[Signature]</i>		22c. DATE SIGNED 7/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES K. AIKINS		22e. ADDRESS ST. Agnes Hospital Baltimore	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 07-13-87	23c. NAME OF CEMETERY OR CREMATORY Security Process	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Balto. MD
24. FUNERAL DIRECTOR NAME 299 Frederick Road 21228 ADDRESS Cremation Society of MD, Baltimore, MD		25a. DATE REC'D. BY REGISTRAR JUL 14 1987	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please attach carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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RECEIVED
JAN 10 1978
FBI - NEW YORK

Continuation of FD-302 of [illegible]
[illegible]

061794 AUG-5 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 / 2027

1. DECEASED NAME (TYPE OR PRINT) ALMA L. WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR JULY 31, 1987		2b. HOUR 6:45 AM	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 13 18		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHURCH HOME HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISABLED		12b. KIND OF BUSINESS OR INDUSTRY N/A				
13a. STATE MD		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		
14. FATHER'S NAME FIRST MIDDLE LAST TIMOTHY DANIELS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELUA SAMPSON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-12-3617		17. INFORMANT HESTER BROWN 280 S. BALLOU CT. 21205		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from JULY 25, 1987, to JULY 31, 1987, that (I) (we) last saw the deceased alive on JULY 31, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Paul Gormley</i>		DEGREE MD		22c. DATE SIGNED 7/3/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL GORMLEY M. D.		22e. ADDRESS CHURCH HOSPITAL CORP. 100 N. BROADWAY BALTIMORE, MD. 21231				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/5/87		23c. NAME OF CEMETERY OR CREMATORY EASTVIEW CEMETERY		
23d. LOCATION CITY OR TOWN COUNTY STATE DUNDALK, Prince Georges Park		23e. DATE REC'D BY REGISTRAR AUG 04 1987				
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.		24b. ADDRESS 1101 E. NORTH AVE.				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, fracture, trauma, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

061204 WRS-203

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DE C146 ST 615

DOY 2.1 11/10/00 14

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AUG 04 1981

San Francisco

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
7. SEX		8. RACE		9. DATE OF BIRTH		10. MONTH		11. DAY		12. YEAR	
13. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		14. CITIZEN OF WHAT COUNTRY?		15. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		16. BALTIMORE CITY OR COUNTY OF DEATH		17. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		18. KIND OF BUSINESS OR INDUSTRY	
19. CITY OR TOWN OF DEATH		20. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		21. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		22. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		23. STREET ADDRESS / ZIP CODE		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
25. STATE		26. COUNTY		27. CITY OR TOWN		28. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		29. STREET ADDRESS / ZIP CODE		30. min	
31. FATHER'S NAME (TYPE OR PRINT)		32. MOTHER'S MAIDEN NAME (TYPE OR PRINT)		33. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		34. SOCIAL SECURITY NO.		35. INFORMANT ADDRESS		36. 21201	
37. ARCHIE		38. WILLIAMS SR		39. YES		40. W.W. II		41. 22716 4611		42. MRS HORTENSE WILLIAMS 1100 BOSTON ST	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										min	
IMMEDIATE CAUSE (a)										minutes	
DUE TO, OR AS A CONSEQUENCE OF										years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										years	
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
CUA in 1984											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from 7/1/87 to 7/31/87 that (we) lost above, (we) (did) (did not) view the body after death.											
22b. SIGNATURE DR Gladue, MD. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED 7/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond Gladue										22e. ADDRESS 611 S. Charles St. 21230	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		8-5-87		GARRISON FOREST		BALTO CO, MD					
24. FUNERAL DIRECTOR NAME ADDRESS										25. DATE REC'D. BY REGISTRAR 26. REGISTRAR'S SIGNATURE	
JOSEPH L. Russ 2222 W. NORTH AVE										AUG 5 1987 Julia Davidson-Randall	

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "OFFICE" and "MEMORANDUM" are faintly visible.]

060263 JUL 22 07

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER. EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20276

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME (PRINT)		DATE KNOWN OF DEATH		HOUR	
DARRIN Lamont WILLIAMS		7-12-87		M	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Male	Black	Sept. 28, 1966	20	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Washington, DC		United States		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		University Hospital STU		Apprentice/Sheet Metalist	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Prince Georges Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS	
Lamont Raymond Williams		Carol Adele Adams		(20770)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		214-86-3566		8015 Mandan Road, Apt. 302; Carol A. Adams (mother) Greenbelt, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Multiple injuries					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		7:42PM 7-11-87		passenger in an auto/auto collision	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		hwy.		I-95 Northbound Lane Baltimore, Maryland	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Margarita A. Korell, M.D.		Assistant		7-13-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Margarita A. Korell, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		07/18/87		Fort Lincoln Cemetery, Brentwood, P.G. Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
LATNEY's Funeral Home		JUL 21 1987		Julia Dandridge-Randall	
3831 Georgia Avenue, N.W.; Washington, DC					

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JUL 22 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87

REG. NO.

20277

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dock F. Williams		2a. DATE OF DEATH MONTH DAY YEAR 7 8 '87		2b. HOUR 3 a.m.	
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 6 1 1887	
6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Manor Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md					
13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1305 Divison Street		21217			
14. FATHER'S NAME FIRST MIDDLE LAST Lou (Luke) Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgianna Davis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Army WWI 212-05-2009		17. INFORMANT ADDRESS Randolph Turpin 1546 Upshire Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yds					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Pleural effusion with non-specific changes in lung</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-10-87</u> , 19 <u>87</u> , to <u>July 8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>July 8</u> , 19 <u>87</u> , and that in (my, our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Manuel Levin</u>		DEGREE MD		22c. DATE SIGNED 7/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MANUEL LEVIN, M.D.		22e. ADDRESS 601 PE HORS AVE BALTO MD 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/13/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest Vet	
23d. LOCATION CITY OR TOWN COUNTY Owings Mills MD					
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR JUL 10 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. Page 4 may be retained by the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000121 JUL 25 81



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE AND PRINT) Edwin Williams			2a. DATE OF DEATH MONTH DAY YEAR 7/19/87		2b. HOUR MIN. 5:40 A M		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 27 15		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.	
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Burn Secours Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beth Steel	
13a. STATE Md		13b. COUNTY Balto		13c. CITY OR TOWN Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Christopher Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Madison		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			
16b. SOCIAL SECURITY NO. 220-03-4101		17. INFORMANT ADDRESS Phyllis Margaret Williams 969 Ellcott Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer of Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Liver and Gall DUE TO, OR AS A CONSEQUENCE OF (c) Hepato Renal Syndrome							
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (his hospital) attended the deceased from July 10 19 87 to July 19 19 87 , that (I) (we) lost saw the deceased alive on July 18 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernardo P. Gonzalez Jr		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED July 19/87	
22d. PHYSICIAN'S NAME (TYPE AND PRINT) Bernardo P. Gonzalez Jr		22e. ADDRESS 2000 W. Baltimore St., Md. 21223					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/25/87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest VA		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills MD	
24. FUNERAL DIRECTOR NAME Wm. C. March				F/H West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR JUL 23 1987	
				25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

2
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. AIR FORCE
HEADQUARTERS
1000 10th St
WASH DC 20330

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058797 JUL 19

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return card onoppers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20279

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLOISE Dowell WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 7 4 1987			2b. HOUR 12:05 P.M.	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 15 08		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Summerton S.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD	
10. CITY OR TOWN OF DEATH Baltimore Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Med. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY DOWELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH JONES		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 217-22-8921		16c. DATE OF DEATH 7/10/87		17. INFORMANT Daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Irreversible shock DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured Hepatic artery aneurysm							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from 7/1/87 to 7/4/87 , that (b) (we) lost saw the deceased alive on 7/4/87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Z.N. Lahiri		DEGREE		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Z. N. LAHIRI		22e. ADDRESS Liberty Medical Center Baltimore, Md. 21215		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/10/87		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD	
24. FUNERAL DIRECTOR NAME ADDRESS LEROY O. DYETT 4600 LIBERTY HEIGHTS				25a. DATE REC'D. BY REGISTRAR JUL 07 1987		25b. REGISTRAR'S SIGNATURE John Davidson-Rudolf	



1. Name		2. Address		3. City		4. State		5. Zip	
6. Phone		7. Birth Date		8. Blood Type		9. Religion		10. Occupation	
11. Education		12. Marital Status		13. Number of Children		14. Date of Last Contact		15. Date of Birth	
16. Date of Death		17. Cause of Death		18. Place of Burial		19. Date of Burial		20. Date of Interment	
21. Date of Cremation		22. Date of Disposition		23. Date of Return		24. Date of Receipt		25. Date of Release	
26. Date of Transfer		27. Date of Discharge		28. Date of Admission		29. Date of Discharge		30. Date of Admission	
31. Date of Discharge		32. Date of Admission		33. Date of Discharge		34. Date of Admission		35. Date of Discharge	
36. Date of Admission		37. Date of Discharge		38. Date of Admission		39. Date of Discharge		40. Date of Admission	
41. Date of Discharge		42. Date of Admission		43. Date of Discharge		44. Date of Admission		45. Date of Discharge	
46. Date of Admission		47. Date of Discharge		48. Date of Admission		49. Date of Discharge		50. Date of Admission	
51. Date of Discharge		52. Date of Admission		53. Date of Discharge		54. Date of Admission		55. Date of Discharge	
56. Date of Admission		57. Date of Discharge		58. Date of Admission		59. Date of Discharge		60. Date of Admission	
61. Date of Discharge		62. Date of Admission		63. Date of Discharge		64. Date of Admission		65. Date of Discharge	
66. Date of Admission		67. Date of Discharge		68. Date of Admission		69. Date of Discharge		70. Date of Admission	
71. Date of Discharge		72. Date of Admission		73. Date of Discharge		74. Date of Admission		75. Date of Discharge	
76. Date of Admission		77. Date of Discharge		78. Date of Admission		79. Date of Discharge		80. Date of Admission	
81. Date of Discharge		82. Date of Admission		83. Date of Discharge		84. Date of Admission		85. Date of Discharge	
86. Date of Admission		87. Date of Discharge		88. Date of Admission		89. Date of Discharge		90. Date of Admission	
91. Date of Discharge		92. Date of Admission		93. Date of Discharge		94. Date of Admission		95. Date of Discharge	
96. Date of Admission		97. Date of Discharge		98. Date of Admission		99. Date of Discharge		100. Date of Admission	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20280
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR		
ELSI E WILLIAMS			JUL 17 1987			8:23 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		
F	B	2 14 38	49 YRS.	MONTHS	DAYS	JUL 17 1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
N.C.	U.S.A.				Baltimore City MD			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore			FRANKLIN SQUARE			S.S.A.		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS			
MD				BALTO.	21206 6102 St. Regis RD			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
ZENO BROWN			Thelma Perkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO			213-46-3831		Hermanione McCargo 736 Mallory Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIO</u> DUE TO, OR AS A CONSEQUENCE OF <u>VASCULAR DISEASE</u> (b) <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
PAUL F. GUERIN			DEPUTY			7/10/87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			1241 KREGER AVE BALTIMORE MD 21237		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)		
Burial			7/13/87	Baltimore Cemetery		BALTO. MD		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D BY REGISTRAR		
March Funeral Home			110 E. NORTH AVE			JUL 13 1987		
						25b. REGISTRAR'S SIGNATURE		
						Julia Davidson-Randall		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))



060052 JUL 21 87

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

20281

1. DECEASED NAME FIRST MIDDLE LAST ETHEL CALDWELL WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 7/4/87		2b. HOUR 10 PM
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 2 21 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. CAROLINA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC (MAID)	12b. KIND OF BUSINESS OR INDUSTRY GLEN L. MARTIN	
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3201 PHELPS LANE 21229
14. FATHER'S NAME FIRST MIDDLE LAST JOHN WESLEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCIS PINKNEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.		16b. SOCIAL SECURITY NO. 219-12-5795	17. INFORMANT MS. BALTIMORE, MARYLAND ETHEL WILSON 3201 PHELPS LANE 21229		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory and Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Corn a 2° to CVA's (multiple)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Gram - ve bacteremia.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>6/25</u> , 19 <u>87</u> , to <u>7/4</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/4</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Monla</u>		DEGREE		22c. DATE SIGNED 7/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MONLA		22e. ADDRESS 900 S CATON AVE Balto MD 21229			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/10/1987	23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MD.	
24. THE BAILEY FUNERAL HOME 1348 N. CALHOUN ST, BALTO, MD. 21217				25a. DATE REC'D. BY REGISTRAR JUL 15 1987	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

18505

080025 JUL 51 01

100% COTTON FIBER

JUL 51 01

0597-51

FOR Film G630 item 18,22 8/11/87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRATION UNKNOWN #87-69

20282

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Gail D. Williams

2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR
7 1 1987

2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR
7 9 1987

2c. DATE PRONOUNCED DEAD MONTH DAY YEAR
7 9 1987

2d. HOUR MIN.
4:10 P.M.

3. SEX F 4. RACE N 5. DATE OF BIRTH MONTH DAY YEAR
4-13-33 34 YRS.

6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN.
34 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
G.A.

7b. CITIZEN OF WHAT COUNTRY?
U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City, 30 MD.

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
3024 Spaulding Ave.

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
LABOR

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE M.D. 13b. COUNTY 13c. CITY OR TOWN BALTO.

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS 1004 W. 41ST STREET #21211

14. FATHER'S NAME FIRST MIDDLE LAST
MONROE WILLIAMS

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
JIMMY LEE DAVIS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO. 215-60-5136 17. INFORMANT ADDRESS CURTIS WILLIAMS 1004 W. 41ST #21211

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). Oral injuries and upper airway obstruction
DUE TO, OR AS A CONSEQUENCE OF
(b).
DUE TO, OR AS A CONSEQUENCE OF
(c).
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
? P.M. unknown 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
subject suffocated

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒
AT WORK AT WORK
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
home
21f. LOCATION CITY OR TOWN COUNTY STATE
3024 Spaulding Ave. Baltimore City Maryland

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐.

22b. TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER
DATE SIGNED 7-10-87

22c. EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn St., Balto. Md. 21201

23a. BURIAL, CREMATION, REMOVAL (specify) 7/13/81 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY BALTO. Cem. 23d. LOCATION CITY OR TOWN COUNTY STATE
BALTO. M.D.

24. FUNERAL DIRECTOR NAME ADDRESS
Betts Funeral Home 1124 N. Cardine 1st
25a. DATE REC'D. BY REGISTRAR JUL 14 1987 25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84 25M BP 666 DHMH - 17 (VR A15 ME (5))

58508 12

20% COTTON FIBER

CHILD WASHABLE



060664

FOR
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20283

1 DECEASED NAME (TYPE OR PRINT) Grace C Williams			2a. DATE OF DEATH MONTH DAY YEAR 7-21-87		2b. HOUR 8:50 A.M.
3 SEX Female	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 11-09-13		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? US OF A	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Inns of Ever Green Central		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1118 Steddard Ct 21201	
14 FATHER'S NAME FIRST MIDDLE LAST JOSEPH DORSEY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISA BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-20-1110	17 INFORMANT ADDRESS MRS. GENELEVE HUTTO 705 N. CALHOUN STREET			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute M.I. DUE TO, OR AS A CONSEQUENCE OF (b) ASHT DUE TO, OR AS A CONSEQUENCE OF (c) Many years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) CVA & @ Hemiplegia, HTN					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-10-86 to 7-21-87 that (I) (we) lost saw the deceased alive on 7-21-87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Shaukat Y. Khan	DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 7-22-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAUKAT Y. KHAN		22e. ADDRESS BALTO. MD 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/25/87	23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE (BALTO.) MD.		
24 FUNERAL DIRECTOR NAME LEWIS T. GWYNN		ADDRESS 4517 PARK HEIGHTS AVE. 21215	25a. DATE REC'D. BY REGISTRAR JUL 23 1987		
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

000004 JUL 24 61

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UNITED

UNITED

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF ECONOMIC ANALYSIS
WASHINGTON, D. C. 20540



x

DOWN

COTTON FIBER

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF ECONOMIC ANALYSIS
WASHINGTON, D. C. 20540

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF ECONOMIC ANALYSIS
WASHINGTON, D. C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. This certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20284

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Harrieth M Williams</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>7 22 87</i>		2b. HOUR <i>12 MN</i>	
3. SEX <i>female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1 29 96</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balti</i> MD.	
10. CITY OR TOWN OF DEATH <i>Balti</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Moson F Lord N Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY -----
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY ---	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Schultz</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida Suter</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-54-7694</i>		17. INFORMANT ADDRESS <i>Ida E. Pfeffer 600 Light St. 21230</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>MINUTES</i>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		
(b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

GASTROINTESTINAL BLEEDING, DEMENTIA

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3/19</i> 19 <i>87</i> , to <i>7/22</i> 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>7/22</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Joseph Ouslander</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>7/22/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH OUSLANDER</i>				22e. ADDRESS <i>5200 EASTERN AVE BALT 21224</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>07/25/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Howard Co. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Lilly & Zeiler Inc. 1901 Eastern Ave.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUL 23 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Joseph Ouslander</i>	

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061217 JUL 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH20285
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ina B. Williams			2a. DATE OF DEATH MONTH DAY YEAR July 22, 1987			2b. HOUR 4:00 P.M.					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 22 13		6. AGE (IN YEARS, LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1240 Woodbourne Ave. 21239		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Barnes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 149-12-8623	
17. INFORMANT ADDRESS Mary Carey 1240 Woodbourne Ave.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Staph aureus, Methicillin resistant</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>A/D; Dementia; Chronic renal failure</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>July 19</u> , 19 <u>87</u> , to <u>July 22</u> , 19 <u>87</u> , that (1) <u>we</u> lost saw the deceased alive on <u>22 July</u> , 19 <u>87</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> (did) (did not) view the body after death.											
22b. SIGNATURE <u>David Sung</u>			DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>22 July 1987</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>David Sung</u>			22e. ADDRESS <u>Liberty Medical Center</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>7/25/87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>King Mem. Pk.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto Co. MD</u>				
24. FUNERAL DIRECTOR NAME ADDRESS <u>Wm. C. March E/H 1101 E. North Ave</u>						25a. DATE REC'D. BY REGISTRAR <u>JUL 28 1987</u>		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

MEDICAL CERTIFICATION

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9

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20286

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			20. DATE KNOWN OF DEATH			21. DATE PRONOUNCED DEAD			22. HOUR		
FIRST MIDDLE LAST JOHN WILLIAMS			MONTH DAY YEAR 7 8 19 87			MONTH DAY YEAR 7 8 19 87			M 10:12 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.						
Male	Black	MONTH DAY YEAR 6 18 24	LAST BIRTHDAY 63 YRS.	MONTHS DAYS	HOURS MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
Va.			U.S.A.			NEVER MARRIED WIDOWED DIVORCED			Baltimore City MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			2566 Salerno Place			Retired					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS							
Md.		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2566 Salerno Place 21230							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Frank Williams				FIRST MIDDLE LAST Mary Hall							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
Yes				216-16-8081				Emma Williams 2566 Salerno Place			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease		
DUE TO, OR AS A CONSEQUENCE OF		
(b)		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>	Inspection <input type="checkbox"/>	Inquiry <input checked="" type="checkbox"/>	and in my opinion
death resulted from		Natural causes <input checked="" type="checkbox"/>	Accident <input type="checkbox"/>	Suicide <input type="checkbox"/>	Homicide <input type="checkbox"/>
				Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE	TITLE (SPECIFY)		DATE SIGNED		
<i>Mario F. Golle, Jr.</i>	M.D. Assistant		7-8-87		
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS				
Mario F. Golle, Jr., M.D.	111 Penn St., Balto., MD 21201				

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	7-14-87	Cedar Hill Cemetery	Anne Arundel Co. Md.
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
March Funeral Home 1101 E. North Ave.		JUL 13 1987	
		25b. REGISTRAR'S SIGNATURE	
		<i>John Davidson</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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JUL 19 1964

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20287
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY E. WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 7 24 87		2b. HOUR 9:42 PM
3. SEX F	4. RACE B 2	5. DATE OF BIRTH MONTH DAY YEAR 5 18 27		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTO.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 946 HOMESTEAD STREET 21218
14. FATHER'S NAME FIRST MIDDLE LAST JOHN SINGLETERY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLADYS HORN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO		16b. SOCIAL SECURITY NO. 219-18-6938	17. INFORMANT MARGARET FOSTER	ADDRESS 946 HOMESTEAD STREET	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain herniation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>embolic cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH onset 7/21/87
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes mellitus</u>					
19a. DATE OF OPERATION NA.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION CITY OR TOWN COUNTY STATE N/A	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 21</u> 19 <u>87</u> , to <u>July 24</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>July 24</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Cara L. Davis</u>				DEGREE MD	22c. DATE SIGNED 7/24/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cara L. Davis, M.D.				22e. ADDRESS Union Memorial Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/28/87	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD	
24. FUNERAL DIRECTOR NAME WM C MARCH F/H				25. DATE REC'D. BY REGISTRAR JUL 28 1987	
				25b. REGISTRAR'S SIGNATURE <u>Julia Borden-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20288
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE MADELINE LAST WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR JULY 30, 1987		2b. HOUR M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 16, 1925		6. AGE (IN YEARS LAST BIRTHDAY) YRS 62 MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4208 GRACE COURT		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTODIAL RETIRED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD			13b. COUNTY BALTO. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT LEE JOHNSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGDALENE M. (GABRIEL)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-22-2353		17. INFORMANT ADDRESS Gabriel Amoss, 5807 Bland Ave. Balto. 21215					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>2 years</u> <u>3 years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4-28-87</u> to <u>7-23-87</u> , that (I) <u>never</u> lost sight of the deceased alive or above, (I) <u>did not</u> view the body after death, and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <u>[Signature]</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1 Aug 87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. R. GIBBLETT</u>			22e. ADDRESS <u>810 Pennington Ave</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8-3-87		23c. NAME OF CEMETERY OR CREMATORY MEADOWBRIDGE MEM. PK		23d. LOCATION CITY OR TOWN COUNTY STATE EUKRIDGE HOWARD MD.		
24. FUNERAL DIRECTOR NAME ADDRESS McGully Funeral Home 237 Papasco Ave. Balto, MD 21225			25a. DATE REC'D. BY REGISTRAR AUG 4 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

MEDICAL CERTIFICATION

29

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 172 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

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[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Phillip J. Williams			2a. DATE OF DEATH MONTH DAY YEAR 7 9 87		2b. HOUR M
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1 8 38		6. AGE (IN YEARS LAST BIRTHDAY) 49	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) La.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 633 MCKEWIN AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISAB.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 633 MCKEWIN AVE. 21218	
14. FATHER'S NAME FIRST MIDDLE LAST ALPHE WILLIAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JUSTINE NOEL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO 433562872		17. INFORMANT ADDRESS ANNIE WILLIAMS 633 MCKEWIN AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Esophageal Carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Davis M. Hahn		DEGREE MD		22c. DATE SIGNED 7/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Davis M. Hahn		22e. ADDRESS 5601 Loch Raven Blvd 21239			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/13/87		23c. NAME OF CEMETERY OR CREMATORY PELLERIN F. H.	
23d. LOCATION CITY OR TOWN COUNTY STATE LAFAYETTE, LOUISIANA		23e. DATE RECEIVED BY REGISTRAR JUL 15 1987			
24. FUNERAL DIRECTOR NAME Wm C March F/H		24b. ADDRESS 1101 E. North Ave.		25. REGISTRAR'S SIGNATURE Julia Gordon-Kendall	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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1948 B. III

59342 JUL 14

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20290

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Rashid A Williams			2a. DATE KNOWN OF DEATH ESTIMATED 7/ 8/ 19 87			2b. HOUR M 11:00 PM		
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 9 14 12 15 YRS.	6. AGE (IN YEARS) (LAST BIRTHDAY) 15 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 7/ 8/ 19 87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Balto. City		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST David Williams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Wade		13e. STREET ADDRESS 3707 Hayward Ave 21215				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-80-6082		17. INFORMANT ADDRESS Linda Williams 3707 Hayward Ave				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR 8:00 MONTH DAY YEAR 3:51 P.M. 7/ 8/ 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot self			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (ATHOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3707 Hayward Ave., Balto. City, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Dennis F. Smyth			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER DATE SIGNED 7/9/87		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-13-87		23c. NAME OF CEMETERY OR CREMATORY EASTVIEW Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME WM. C. BROWN			ADDRESS 1206 W. North Ave		25a. DATE REC'D BY REGISTRAR JUL 13 1987		25b. REGISTRAR'S SIGNATURE Julia Dandridge-Randall	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD, "PENDING" IN PENCIL AFTER 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TOMB, OR PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20291

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROY WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 7 11 87		2b. HOUR M
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 4 21 19		6. AGE (IN YEARS, LAST BIRTHDAY) 68 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1332 STONEWOOD RD. 21239		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY MD. DRYDOCK CO.
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR WILLIAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SALLY WINSTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 218-10-4519	17. INFORMANT ADDRESS JENNIE B. WILLIAMS 1332 STONEWOOD RD. 21239		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>wildfire caused by car accident - stroke</u> <u>7/11/87</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>87</u> to <u>7/11</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>7/11</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Alan Kimmel</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>7/13/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kimmel</u>		22e. ADDRESS <u>220 W Cold Spring La 21210</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7/17/87	23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VETERAN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS, MD.	
24. FUNERAL DIRECTOR NAME WILLIAM C. MARCH F/H 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 14 1987			
		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Rudman</u>			

BP

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20292

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	M
Shaldena				Williams	July 28, 1987						
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female	Black	11 1 24		62		YRS		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
SOUTH CAROLINA	USA			Baltimore City MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore	203 N. Bethel Ct.			UNKNOWN							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MD						BALTO.				203 BETHEL CT. 21231	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
JOHN HENRY LEBBY				MARY ARGO LEBBY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO				N/A		MR. VERNON LEBBY		3954 WISLBY AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 1</u> , 19 <u>87</u> , to <u>JUNE 30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>MAY 19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Bradley M. Denker</u>				DEGREE <u>MD</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>7/29/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BRADLEY M. DENKER</u>				22e. ADDRESS <u>600 N. WOLFE ST. BALTO MD 21205</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		8-1-87		Mt. Arburn Cem.		BALTO.				MD	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H 1101 E. North Ave.				JUL 30 1987							

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return this page to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP _____

2012 COTTON EIBELS

CHIEFMAN



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JUL 30 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR		REG. NO. 30293	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE OF DEATH	
FIRST MIDDLE LAST Dorothy Rose Willis		MONTH DAY YEAR 7 8 87	
21. HOUR 8:40AM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Female	White	8 ^{ONTH} 14 1897	89
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.		Baltimore City MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Meridian Long Green Nursing Home	Librarian	Enoch Pratt
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. CITY OR TOWN
Maryland	Baltimore	Baltimore	Baltimore
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.
FIRST MIDDLE LAST Richard H.D. Willis	FIRST MIDDLE LAST Rose E. Donohue	No	219-22-1417
17. INFORMANT	ADDRESS	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
Victoria Flanigan	227 Crocker Dr.	PART I. DEATH WAS CAUSED BY:	
		IMMEDIATE CAUSE (a) <u>Dementia</u>	
		DUE TO, OR AS A CONSEQUENCE OF	
		(b) <u>Pneumonia</u>	
		DUE TO, OR AS A CONSEQUENCE OF	
		(c) <u>Dehydration</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/28</u> 19 <u>86</u> , to <u>7/8</u> 19 <u>87</u> , that <u>we</u> saw the deceased alive on <u>7/8</u> 19 <u>87</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE	DEGREE	22c. DATE SIGNED	
<u>John W. Bowie MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	<u>7/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS		
John W. Bowie	500 W. University Pkwy.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Cremation	7-10-87	Greenmount	Baltimore City Maryland
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Mitchell-Wiedefeld Home	6500 York Rd. 21212	<u>Julia Swanson-Randall</u>	

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Name Title Date

Mr. J. W. Smith

Catholic Priest

St. John's Church

St. John's Church

St. John's Church

St. John's Church

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St. John's Church

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20295

1. DECEASED NAME (TYPE OR PRINT) GEORGE O. WILSON			2a. DATE KNOWN OF DEATH 7-18-87			2b. HOUR 9:10A		
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH 12 2 97	6. AGE (IN YEARS) 89 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 7-18-87		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		9b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		

10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 1623 N. Broadway		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNKNOWN		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME UNKNOWN		15. MOTHER'S MAIDEN NAME UNKNOWN		13e. STREET ADDRESS 1623 N. BROADWAY STREET			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 220-20-5117		17. INFORMANT MR. JERRY ASBOURNE		17b. ADDRESS 1623 N. BROADWAY ST.	
---	--	---	--	-------------------------------------	--	--------------------------------------	--

18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held a death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE John E. Smialek, M.D.		TITLE (SPECIFY) M.D. Chief MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED 7-18-87	

23a. BURIAL, CREMATION, REMOVAL (SEE ITEM 18) BURIAL		23b. DATE 7/30/87		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST VA.		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILLS MD	
24. FUNERAL DIRECTOR WM MARCH FUNERAL HOME 1101 E. NORTH AVENUE				25a. DATE REC'D. BY REGISTRAR JUL 30 1987		25b. REGISTRAR'S SIGNATURE	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. RETAIN PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PERMITS. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MD. 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been verified by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page must be submitted to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE REGISTRAR		8		REG. NO. 20290					
1. DECEASED NAME (TYPE OR PRINT) GERTRUDE O. WILSON				2a. DATE OF DEATH MONTH DAY YEAR 07 10 87		2b. HOUR 7:50 PM			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 10 20 91		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (CITY OR TOWN, STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALD. CITY MD			
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SOUTH BALTO GENERAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 523 N. Cathoun St 21222	
14. FATHER'S NAME Alfred		15. MOTHER'S MAIDEN NAME Stanley		16. SOCIAL SECURITY NO. 218096199		17. INFORMANT ADDRESS DORICE Milligian 7080 Gandle Rock Way			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		18b. SOCIAL SECURITY NO. 218096199		18c. CITY OR TOWN BALTO		18d. STREET ADDRESS / ZIP CODE 523 N. Cathoun St 21222			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from July 9, 19 87, to July 10, 19 87, that (we) last saw the deceased alive on July 10, 19 87, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.									
22b. SIGNATURE P. BARBERS JR						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7.10.87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. BARBERS JR		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-15-87		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co. Md.			
24. FUNERAL DIRECTOR March Funeral Home 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR JUL 14 1987		25b. REGISTRAR'S SIGNATURE	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20297

1. DECEASED NAME (TYPE OR PRINT)			2b. DATE KNOWN OF DEATH			2c. DATE PRONOUNCED DEAD			2d. HOUR		
HARRY WILSON			7 20 19 87			7 20 19 87			12:45 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
M	W	11 02 58	33 RS.	MONTHS	DAYS	NEVER MARRIED	Baltimore City			MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore			U.S.A.			WIDOWED			Baltimore City		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			Key Medical Center								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MD.			BALTO.						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
						UNKNOWN			212-52-8263		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DR. GALLETT - FRANCIS SCOTT KEY						9108 IMMEDIATE CAUSE (a) Multiple neck injuries					
						DUE TO, OR AS A CONSEQUENCE OF					
						(b)					
						DUE TO, OR AS A CONSEQUENCE OF					
						(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			3:58 P.M. 7-19-1987			Subject dove into water.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			21g. LOCATION		
			pier			Worster Pier			Edgemere		
						Baltimore			MD		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED					
			Deputy Chief			7-21-87					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		
Ann M. Dixon, M.D.			111 Penn St., Balto., MD 21201			REMOVAL			8-5-87		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY DEPARTMENT			25b. REGISTRAR'S SIGNATURE		
State Anatomy Board			Balto., Md.			AUG 12 1987			Julia Schaefer-Rublee		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove appropriate pages 1, 2, and 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 20298

1. DECEASED NAME (TYPE OR PRINT) FIRST <i>Helen</i> MIDDLE <i>Elizabeth</i> LAST <i>Wilson</i>		2a. DATE OF DEATH MONTH <i>7</i> DAY <i>12</i> YEAR <i>87</i>		2b. HOUR <i>13:06 M</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>9</i> DAY <i>7</i> YEAR <i>16</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Francis Scott Key Medical Center</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>			
13a. STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. STREET ADDRESS / ZIP CODE <i>410 Kane Street 21224</i>	
14. FATHER'S NAME FIRST <i>Alexander</i> MIDDLE <i>David</i> LAST <i>Jr.</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i> MIDDLE <i>Breck</i> LAST <i>Breck</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-07-4004</i>		17. INFORMANT ADDRESS <i>Luther B. Wilson 410 Kane St. 21224</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory and cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sepsis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Multi-infarct dementia, CVA, left cerebrovascular accident, recurrent UTIs.</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Clifford S. Mitchell M.D.</i>				22c. DATE SIGNED <i>7/12/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Clifford S. Mitchell</i>				22e. ADDRESS <i>4940 Eastern Avenue Baltimore, MD 21224</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7-16-87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eastwood, Balto., Co., Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler & Son Inc.</i>				25. DATE REC'D. BY REGISTRAR <i>JUL 15 1987</i>	
ADDRESS <i>6224 Eastern Ave.</i>				75b. REGISTRAR'S SIGNATURE <i>Julia Swisher-Lindale</i>	

BP

060534 JUL 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20299

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RONALD W WILSON			2a. DATE OF DEATH MONTH DAY YEAR 7 21 87		2b. HOUR 4:42 PM		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 - 1 - 32		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 54	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2301 Monticello Rd		14. FATHER'S NAME FIRST MIDDLE LAST Lawrence Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances E. Williams	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes 1950-1952		16b. SOCIAL SECURITY NO. 315-28		17. INFORMANT ADDRESS Addie Wilson 2301 Monticello Rd		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Hepato-renal syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia, Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a his condition. He was on a recurrent Pneumonia							
19a. DATE OF OPERATION 7-19-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Renal FAILURE - DIALYSIS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/29/87 19____, to 7/20/87 19____, that (I) (we) last saw the deceased alive on 7/20/87 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE MD		22c. DATE SIGNED 7/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PELAYO E. CORREA				22e. ADDRESS LIBERTY MEDICAL CENTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-27-87		23c. NAME OF CEMETERY OR CREMATORY Garrison Forest		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md	
24. FUNERAL DIRECTOR NAME Brown Thompson F.H.				25. DATE REC'D BY REGISTRAR JUL 22 1987		REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please return the completed pages, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

060234 JUL 23 81

Handwritten notes and a table. The table has multiple columns and rows of data, though the text is mostly illegible due to fading. Some visible words include "TABLE", "DATA", and "RESULTS".

060234 JUL 23 81

060679 JUL 24 87

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 / 20300
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Baby Girl (Tmerac Wilson)		2a. DATE OF DEATH MONTH DAY YEAR 7 15 87		2b. HOUR 12:50 AM	
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 7 12 87		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 3 3	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MO	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt MD	
10. CITY OR TOWN OF DEATH Balt	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MO	13b. COUNTY Balt	13c. CITY OR TOWN Balt	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 22 S. Green 21201	
14. FATHER'S NAME FIRST MIDDLE LAST Scott Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vivian R Falcon		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Helen Parnell 1243 W. Lombard 21223			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cardio-Pulmonary ArrestAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**~2 hrs**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.(b) **Respiratory Failure**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Seven Precedents with Myocardial Disease ~3 days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/12 , 19 87 , to 7/15 , 19 87 , that (I) (we) lost saw the deceased alive on 7/15 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael Beane		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Beane MD		22e. ADDRESS 22 S. Green St Balt MD 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 7-20-87	23c. NAME OF CEMETERY OR CREMATORY EASTVIEW MEMORIAL PK	23d. LOCATION CITY OR TOWN COUNTY DUNDALK MD
24. FUNERAL DIRECTOR NAME MARCH FUNERAL HOMES, INC.		25a. DATE REC'D. BY REGISTRAR JUL 22 1987	
ADDRESS 1101 E. NORTH AVE.		25b. REGISTRAR'S SIGNATURE 1. J. P. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from Page 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

000010 JUL 24 01



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20301

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA WINER		MONTH DAY YEAR JULY 14 1987		6:10 AM.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 07 - 05 1886	6. AGE (IN YEARS LAST BIRTHDAY) 101 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LITHUANIA	7b. CITIZEN OF WHAT COUNTRY? USA?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.		
10. CITY OR TOWN OF DEATH Balto City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Levin Dale HEBREW HOME	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE Md		13b. COUNTY 11	13c. CITY OR TOWN Balto	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1534 W. PATTERSON PARK DR. 21231
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC LEVIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FEIGA DENA MEISTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217 32 9631		17. INFORMANT MAURICE OFFUTT, ATTY. SUITE 202 1107 KENILWORTH DR. TOWSON, MD 21204	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, ASPIRATION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: SENIOR DEMENTIA OF ALZHEIMER'S TYPE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/31, 1981, to 7/14, 1987, that (I) (we) lost saw the deceased alive on 7/14, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE MD		22c. DATE SIGNED 7/14/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. ZAW-LIN, MD		22e. ADDRESS Levin Dale Geriatric Ctr 21215			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 16, 1987		23c. NAME OF CEMETERY OR CREMATORY WORKMEN CIRCLE	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO. MD 21215				25a. DATE REC'D. BY REGISTRAR JUL 21 1987	
				25b. REGISTRAR'S SIGNATURE Julia Dindon-Randall	

BP

060347

JUL 22 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send the carbon papers, Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

080347 JUL 55 01

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the event.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20302

1. FOR STATE REGISTRAR		DECEASED NAME FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
RUBY		WINKLER		JULY 14, 1987		12:10PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
F	N	3-20-37		50			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
M.D.		U.S.A.		BALTIMORE CITY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		Labor			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
M.D.				BALTO.		3223 Avon Ave #2128	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
John Robert		Davis		E/A Mae Currence		212-34-0726	
17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MRS. JACKSON 343 E 21st Street		Cardiac Arrest		30 minutes			
		(b) Cardiac Tamponade		1 hour			
		(c) Metastatic Breast Cancer		1 year			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/14, 19 87, to 7/14, 19 87, that (I) (we) saw the deceased alive on 7/14, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED			
Matthew R. Holland MD		Attending Physician <input type="checkbox"/> Medical Director <input type="checkbox"/> Staff Physician <input checked="" type="checkbox"/>		7/14/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Matthew R. Holland		600 Wolfe St. Baltimore, MD 21205		7/17/87		EASTVIEW CEM.	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	
BALTO.		M.D.		Betts Funeral Home 1129 N. Carolin		JUL 16 1987	
				25b. REGISTRAR'S SIGNATURE			
				Julia Davidson-Hopkins			

BP

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OFFICIAL
MAILING

P. U. S. P. O.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH20303
REG. NO.

2a. DATE KNOWN OF DEATH, ESTI- MATED		MONTH DAY YEAR		7/ 25/ 19 87		2b. HOUR		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.	
male		black		10 31 1925		61 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
S.C.		U S A				Baltimore City,		MD	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY	
2421 Lakeview Ave.		Disabled				Md		Baltimore	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Marion		Janie		No		247-24-3303		Annie Powell	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. CITY OR TOWN		19d. INSIDE CITY LIMITS?		19e. STREET ADDRESS		20. AUTOPSY?	
PART I DEATH WAS CAUSED BY:		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2421 Lakeview Avenue 21217		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
IMMEDIATE CAUSE (a)		Arteriosclerotic Cardiovascular Disease		DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF					
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED					
Margarita A. Korell, M.D.		Assistant		7/26/87					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		7/30/87		Eastview Cemetery		Baltimore MD			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H West		4300 Wabash Avenue		JUL 28 1987					

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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DHMH - 17
(VR A15 ME (1))

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JUL 21 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20304

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
GLADYS I. WOHL		FEMALE		Cau.		July 13, 1903		84		Bluefield W.V.		USA				Baltimore City		Housewife		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE											
Barto		Liberty Medical Center		Md.				Baltimore		YES		3915 W. Cold Spring Ave.		21215									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT															
Arthur		Mary E. Lucas		No		216-12-0129		Mr. John E.L. Conwat												Westminster, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u>																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARDIAC ARRHYTHMIA - ATRIAL FIBILLATION</u>																		MINUTES					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>																		YEARS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HYPERTENSIVE DISEASE, - SEMIPLTY, - ANGINA.</u>																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED																			
		HOUR A.M. MONTH DAY YEAR		N/A		N/A																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION																			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		N/A		N/A		N/A																	
22a. I certify that (I) (this hospital) attended the deceased from <u>18 JULY</u> , 19 <u>87</u> , to <u>18 JULY</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>18-18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE																		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
																		MD				7-18-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																		22e. ADDRESS					
ERNESTO MOLFINO																		2600 Liberty Rd.		Baltimore Md.		21215	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION																	
Burial		7/21/87		Meadow ridge Mem.		Howard CO. Md.																	
24. FUNERAL DIRECTOR																		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Eline Funeral Home																		JUL 20 1987		Julia Davidson-Pendge			
NAME ADDRESS																							
Reisterstown, Md.																							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST MARGARET WOLF				MONTH DAY YEAR July 2, 1987				M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 24, 1907		6. AGE (IN YEARS LAST BIRTHDAY) YRS 79		IF UNDER 1 YEAR MONTHS DAYS 79		IF UNDER 24 HRS HOURS MIN. 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4108 Wilke Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4108 Wilke Ave. 21206			
14. FATHER'S NAME FIRST MIDDLE LAST William Creely				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Dee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-12-9041		17. INFORMANT ADDRESS Mrs. Charlotte King D. Same as #13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colon Cancer with Metastasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure with Pulmonary Fibrosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET 413 Eastern Ave.		CITY OR TOWN Baltimore		COUNTY Maryland		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Maria C. Diaz, M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maria C. Diaz, M.D.				22e. ADDRESS 413 Eastern Ave.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-6-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.				ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR JUL 6 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP

May 2, 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows bullet wound or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) SHIRLEY SHIRLEY		2a. DATE OF DEATH MONTH <u>7</u> DAY <u>22</u> YEAR <u>87</u> 07-22-87		2b. HOUR 11:55 PM	
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH <u>May</u> DAY <u>7</u> YEAR <u>1930</u>		6. AGE (IN YEARS LAST BIRTHDAY) 57 yrs.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Rices Bakery
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13. STREET ADDRESS / ZIP CODE 3727 Ravenwood Avenue 21213			
13a. STATE Md.	13b. COUNTY Balto.	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14. FATHER'S NAME FIRST William MIDDLE Baucher LAST Baucher		15. MOTHER'S MAIDEN NAME FIRST Lola MIDDLE Wells LAST Wells			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217-26-9994		17. INFORMANT ADDRESS Barbara Hubbard 3409 Northway Drive 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: BREAST CANCER with METASTASIS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.					
22b. SIGNATURE <i>Joseph Hubaykah</i>		DEGREE		22c. DATE SIGNED 7-22-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH HUBAYKAH		22e. ADDRESS GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD BALTO-MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-25-87	23c. NAME OF CEMETERY OR CREMATORY Garrison Forest		23d. LOCATION CITY OR TOWN COUNTY STATE Owings Mills, Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213		25a. DATE REC'D BY REGISTRAR JUL 24 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>	

BP _____

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RESPIRATORY ARREST

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21 JUL 01

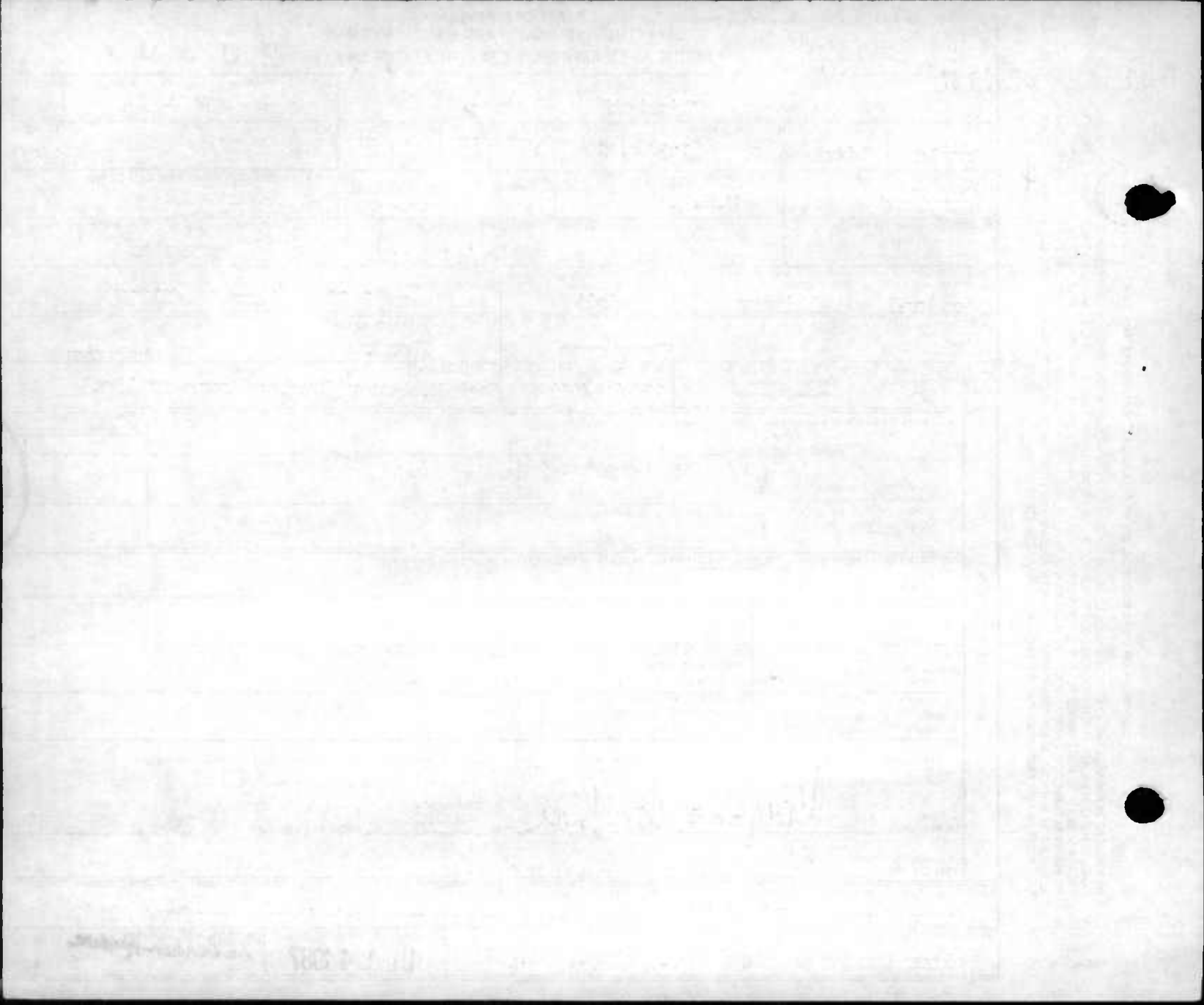
059697 JUL

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WORKING WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items, 18a, 18b, Part II., 21a.-22a., G-630, STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC. NO. 20301		
1- FOR REGISTRAR 8/12/87 1a. DECEASED NAME (TYPE OR PRINT) THERESA Elizabeth WOMER										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 7-13-87 19		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 5 DAY 3 YEAR 1918	6. AGE (IN YEARS) BIRTHDAY 69 YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	IF UNDER 24 HRS. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD MONTH 7 DAY 13 YEAR 19		2d. HOUR 2:26a				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City 30 MD						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Francis Scott Key Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland										13b. COUNTY Baltimore		
13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3013 Dunleer Rd./21222								
14. FATHER'S NAME FIRST John MIDDLE John LAST Przywozna		15. MOTHER'S MAIDEN NAME FIRST Theresa MIDDLE Theresa LAST unknown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213/09/0912B		17. INFORMANT Jack N. Womer (husband same as 13e.)				ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral stenosis DUE TO, OR AS A CONSEQUENCE OF (b) rheumatic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 cellulitis of left arm due to crab bites												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 7 10 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject bitten by a crab								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unk.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE unk.								
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Margarita A. Korell		TITLE (SPECIFY) Assistant						DATE SIGNED 7-13-87				
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.		ADDRESS 111 Penn Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 7/16/1987		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland 21202						
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley, Inc.		ADDRESS Balto., Md. 21222		25a. DATE REC'D. BY REGISTRAR JUL 14 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Hendall						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20308

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MARY T. WOOD		MONTH DAY YEAR JULY 2, 1987		2:17 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE	
Female	White	MONTH DAY YEAR March 8, 1898		89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	USA			Baltimore City MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Maryland General Hospital		Homemaker		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	
Md		--	Baltimore,	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST Edward Taylor		FIRST MIDDLE LAST Mary Susan Beard		213 05 8213	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
No		Katherine Bush,		2211 W. Rogers Avenue 21209	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
(b) <u>Sepsis</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>Acute Pancreatitis</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1987, to July 2, 1987, that (we) lost saw the deceased give up July 2, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Lorraine Henss		225 Greene St Balto MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	
Entombment		7/6/87	Lorraine Park Cemetery	Woodlawn, Balto. Co. Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Burgee-Henss Funeral Home, 3631 Falls Rd 21211		JUL 7 1987		Julia Davidson-Randall	

061126 JUL 28 1987

ITEMS 13a.-BE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20309

FOR STATE REGISTRAR 8-3-87 AL per phone

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
WOODARD BABY GIRL

2a. DATE OF DEATH MONTH DAY YEAR
7 6 87

2b. HOUR
4:15 P M

3. SEX
Female

4. RACE
Black

5. DATE OF BIRTH MONTH DAY YEAR
7 5 87

6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.
18 hours

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
CITY MD

10. CITY OR TOWN OF DEATH
Baltimore

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SINAI Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
27257

12b. KIND OF BUSINESS OR INDUSTRY
Apt. 203

13a. STATE
MD

13b. COUNTY
Baito

13c. CITY OR TOWN
Baito

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS / ZIP CODE
3605 Gatehouse Dr.

14. FATHER'S NAME FIRST MIDDLE LAST

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
UIDA WOODARD

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) asystole
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) prematurity
DUE TO, OR AS A CONSEQUENCE OF (c) resp. distress syndrome

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE
Robinson, Brad

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED
7/6/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BRAD ROBINSON

22e. ADDRESS
SINAI HOSPITAL, BALTIMORE

23a. BURIAL (SPECIFY) CREMATION REMOVAL

23b. DATE
7-10-87

23c. NAME OF CEMETERY OR CREMATORY
SINAI HOSPITAL

23d. LOCATION CITY OR TOWN COUNTY STATE
BALTO MD

24. FUNERAL DIRECTOR NAME
SINAI HOSPITAL 2401 W. BELVEDERE AVE

25a. DATE REC'D. BY REGISTRAR
JUL 28 1987

25b. REGISTRAR'S SIGNATURE
Julia Gordon-Randall

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

081128 JUL 23 81

Form 150

DATE: 10/10/81

10/10/81

10/10/81

10/10/81

10/10/81

10/10/81

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10/10/81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20310

1. DECEASED NAME (TYPE OR PRINT) THELMA M WOODSON				2a. DATE OF DEATH MONTH 7 DAY 17 YEAR 87 9:18pm			
3. SEX F		4. RACE B 2		5. DATE OF BIRTH MONTH 8 DAY 31 YEAR 20		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. City MD.	
10. CITY OR TOWN OF DEATH BAITIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BAITIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Paul MIDDLE Johnson LAST Johnson		15. MOTHER'S MAIDEN NAME FIRST Unkn MIDDLE Unkn LAST Unkn		13e. STREET ADDRESS / ZIP CODE 5551 Midwood Ave 21212			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -		17. INFORMANT Caroline Whitaker ADDRESS 719 Collington Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Refractory Ventricular Tachycardia DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: chronic renal failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/29 19 87 to 7/17 19 87 , that (I) (we) last saw the deceased alive on 7/17 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Tullio Emanuele, MD				DEGREE MD		22c. DATE SIGNED 7/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TULLIO F MANUELE				22e. ADDRESS 5601 LOCH RAVEN BLVD BALTIMORE MD 21239			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE 7/22/87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUL 20 1987	
				25b. REGISTRAR'S SIGNATURE Julia Denson-Rudolph			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

080117 JUL 51 81

101 50 81

060985 JUL 29 87

OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 20311
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CORLELIA GILLIAM WRIGHT			2a. DATE OF DEATH MONTH DAY YEAR 07 20 87		2b. HOUR 8:19 A.M.
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 2 22 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH CITY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST CHARLIE GILLIAM			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HICKIE WYCHE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO.		16b. SOCIAL SECURITY NO. 215-18-7255		17. INFORMANT MR. HENRY L. WRIGHT	
ADDRESS BALTIMORE, MD. 1942 W. FAYETTE ST.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (b) CEREBRAL VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF SENILE DEMENTIA (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 0629 87 0720 87	
22a. I certify that (I) (this hospital) attended the deceased from 7/20 19 87, to 7/20 19 87, that (I) (we) last saw the deceased alive on 7/20 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kuang-yen Huang		DEGREE M.D.		22c. DATE SIGNED 7/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG		22e. ADDRESS BON SECOURS Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/25/1987	23c. NAME OF CEMETERY OR CREMATORY DIAMOND GROVE BAPT. CH.		23d. LOCATION CITY OR TOWN COUNTY STATE SKIPPER'S
24. FUNERAL HOME NAME FUNKER FUNERAL HOMES, INC.		ADDRESS 2501 GWYNNS FALLS PKWY, BALTO. MD. 21216		25a. DATE REC'D. BY REGISTRAR JUL 28 1987	25b. REGISTRAR'S SIGNATURE John D. ...

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers; Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "NOTICE" and "GIVEN" are faintly visible at the bottom.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers-Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20312

REG. NO. 2

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <i>Cornelia H. Wright</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>7 13 87</i>		2b. HOUR <i>6:20 PM</i>	
3 SEX <i>Female</i>		4 RACE <i>Negro</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 6 05</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>BALTO., MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balt. City</i> MD.	
10. CITY OR TOWN OF DEATH <i>BALTO.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SINIA HOSP.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>N/A</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>N/A</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Balt.</i>		13c. CITY OR TOWN <i>Balt.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>ELIJAH HOUSE</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cornelia H. House</i>		13e. STREET ADDRESS ZIP CODE <i>3504 Fawcett Ave 21216</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>unknown</i>		16b. SOCIAL SECURITY NO. <i>215-32-2645</i>		17. INFORMANT <i>William Wright</i>		ADDRESS <i>3504 Fawcett Ave Balt.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>July 12</i> , 19 <i>87</i> , to <i>July 13</i> , 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>July 13</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. Gill MD</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>7-13-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. Gill MD</i>				22e. ADDRESS <i>Sinia Hospital Greensburg, Belvedere</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>7/18/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CREST LAWN CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO., MD.</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>LEROY O. DYETT 4600 LIBERTY HEIGHTS</i>				25a. DATE REC'D. BY REGISTRAR <i>JUL 14 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Della Wright						2a. DATE OF DEATH MONTH DAY YEAR July 24, 1987		2b. HOUR M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 8 96		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5323 Fernpark Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD						13b. COUNTY		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown Massey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-60-2327		17. INFORMANT James E. Mc Donald		ADDRESS 1190 W. Northern Pkwy			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic poor health - advanced age</u>								3 years	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Peter Agre				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7/27/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Agre, M.D.				22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/29/87		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 4300 Wabash Avenue				25a. DATE REC'D BY REGISTRAR JUL 28 1987		25b. REGISTRAR'S SIGNATURE Julia Deaton-Rublee			

MEDICAL CERTIFICATION

081124 JUL 20 07

069635 JUL 24 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 20314

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward Wright Jr.			2a. DATE OF DEATH MONTH DAY YEAR 7-17-87		2b. HOUR 4:55 PM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 18 23		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Wright Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae E. Milbourne		13e. STREET ADDRESS / ZIP CODE 1718 Ruxton Ave. 21216			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-16-4372		17. INFORMANT Willie Mae Hughes 1718 Ruxton Ave. 21216			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordae Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Probable MI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2.3 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Probable large CVA or Intracerebral bleed</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7-11-87, 19 87, to 7-17-87, 19 87, that (I) (we) lost saw the deceased alive on 7-17-87, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Joseph Raduazzo MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 7-17-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Raduazzo, M.D.				22e. ADDRESS Union Memorial Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-24-87		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD		
24. FUNERAL DIRECTOR NAME ADDRESS March Funeral Homes, Inc. 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR JUL 23 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file in the space provided. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENICULIN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20315

1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH		2b. HOUR							
Henry David Wright, Jr.										X MONTH DAY YEAR 7 3 1987		M 5:15 AM							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR								
Male	Black	9 27 58		28 YRS.	MONTHS DAYS HOURS MIN				7 3 1987		5:15 AM								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
North Carolina				USA		WIDOWED		Baltimore City		MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS									
Baltimore				Sinai Hospital				CLERK		SANDS DISTRIBUTING									
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD														BALTIMORE		YES X NO		4946 DENMORE AVE. 21215	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
HENRY				RISER				MARY W. GARDNER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
YES				241-04-6930				WILBERT WRIGHT 4112 EASTMONT AVE. 21213											
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a). Multiple injuries																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES X NO							
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
X				10:30 AM 7-2-1987				Pedestrian struck by auto.											
21d. INJURY OCCURRED WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
NOT WHILE AT WORK X				street				5000 blk. Park Heights Ave., Balto. City, MD											
22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from:																			
Natural causes, Accident X, Suicide, Homicide, Undetermined manner.																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
William M. Zane, M.D.				Assistant				7-3-87											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
William M. Zane, M.D.				111 Penn St., Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
BURIAL				7/13/87				GARRISON FOREST VETERAN CEM.				OWINGS MILLS, MD.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25. DATE REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
WM. C. MARCH F/H 1101 E. North Ave								JUL 10 1987				Julia Davidson-Randall							

07/84
25M

BP

DHMM - 17
(VR AIS ME (S))

100% COTTON EMBROID

WINTER DOWD



061377

JUL 30 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20316

1- FOR
 STATE
 REGISTRAR

2- DECEASED NAME
 (TYPE OR PRINT)

FIRST

MIDDLE

LAST

Valerie

Wright

2a. DATE KNOWN OF DEATH ESTI- MATED ☒ 7/ 25/ 19 87 2b. HOUR M

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE (IN YEARS)

IF UNDER 1 YR.

IF UNDER 24 HRS.

2c. DATE PRONOUNCED DEAD

FEMALE

BLACK

2/15/58

28 YRS.

MONTHS

DAYS

HOURS

MIN.

MONTH DAY YEAR

7/ 25/ 19 87

2d. HOUR M

9:10 P M

7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

Francis Scott Key Medical Center

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

UNION MEM.

12b. KIND OF BUSINESS OR INDUSTRY

BARBER

13a. STATE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

MD

13b. COUNTY

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

4112 EASTMONT AVE. 21213

14. FATHER'S NAME

CLARENCE MASSEY

15. MOTHER'S MAIDEN NAME

ELIZABETH MASSEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

N/A

17. INFORMANT

213-72-9240

ADDRESS

WILBERT WRIGHT 4112 EASTMONT AVE.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intracerebral Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 7/26/87

EXAMINER'S NAME (TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS

111 Penn St.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

7/30/87

23c. NAME OF CEMETERY OR CREMATORY

KING MEM. PK.

23d. LOCATION

BALTO., MD.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

ADDRESS

LEROY O. DYETT 4600 LIBERTY HEIGHTS

25a. DATE REC'D. BY REGISTRAR

JUL 29 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Rudolph

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

081322 JUL 30 81

3813-107100-2004

JUL 30 1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA WYATT					2a. DATE OF DEATH MONTH DAY YEAR 7-2-87					2b. HOUR MIN. 12:15 MA	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11 25 32			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 54yrs.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5934 The Alameda Balto 21239				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cosmetologist			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5934 The Alameda Balto. Md 21239			
14. FATHER'S NAME FIRST MIDDLE LAST EDDIE POWELL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVA ALEXANDER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 180-30-4624			17. INFORMANT ADDRESS ROBERT WYATT 5934 THE ALAMEDA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Metastatic colon carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 3-31-87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adenocarcinoma of cecum				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (X) (s) hospital attended the deceased from 6-18-87 19 87 to 7-2 19 87 , that (I) (we) last saw the deceased alive on 7-1-87 19 87 , and that in (my) (X) (r) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (s) (r) did not view the body after death.											
22b. SIGNATURE <i>Malcolm Wilkinson MD</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/3/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Malcolm wilkinson, M.D.						22e. ADDRESS 8415 Bellona La S212 Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 7-9-87		23c. NAME OF CEMETERY OR CREMATORY GARRISON FOREST		23d. LOCATION CITY OR TOWN COUNTY STATE OWINGS MILL, MD.				
24. FUNERAL DIRECTOR NAME MARCH FUNERAL HOME						ADDRESS 1101 E. NORTH AVE.		25a. DATE REC'D. BY REGISTRAR JUL 7 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randey</i>	

BP

53817 10/11/00 20%

WINTER HILL

1/1/01

WINTER HILL

061260 JUL 30 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 20318

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
James B. Wyatt			X MONTH DAY YEAR 7 26 1987			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
Male	White	July 15, 1922	65 YRS.	MONTHS DAYS HOURS MIN.		7 26 1987	1:15 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
Virginia			U.S.A.			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Baltimore			2525 Maryland Avenue			Salesman		
12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE			13b. COUNTY		
Automobile			Maryland			13c. CITY OR TOWN		
			Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			13e. STREET ADDRESS			13f. CITY OR TOWN		
			2525 Maryland Ave.			21218		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. ADDRESS		
George Wyatt			Mittie Adams			Sweet Valley, PA 18656		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Yes WW II			185-14-6777			Leonard Scavone, RD 1		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Alcoholism</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> XXX	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
			head only					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> XXXXXX, Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Margarita A. Korell</u>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			DATE SIGNED		
Margarita A. Korell, M.D.			111 Penn St., Balto. Md.			21201		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			July 30, 1987		Oak Lawn		Hanover Twnp, Luzerne, PA	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214			JUL 29 1987			Julia Davidson-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

081580 JUL 30 85

100% COTTON

MADE IN U.S.A.



060695 JUL 27 1987

OR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20319

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM A. YEAGY JR.			2a. DATE OF DEATH MONTH DAY YEAR JULY 23, 1987		2b. HOUR P 5:45 M					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 17 1924		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			10. CITY OR TOWN OF DEATH BALTIMORE	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER			12b. KIND OF BUSINESS OR INDUSTRY PORT CITY PRESS			13a. STREET ADDRESS / ZIP CODE 3903 KENYON AVE. 21213	
13a. STATE MD.		13b. COUNTY -		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM A. YEAGY, SR.		
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM A. YEAGY, SR.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GENEVIEVE WRIGHT		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW II 212-20-5253		17. INFORMANT ADDRESS DOLORES YEAGY (WIFE) SAME ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic cardiovascular disease unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>50 minutes</u> <u>90 minutes</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>history of rheumatic fever and AORTIC STENOSIS</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>7/23</u> , 19 <u>87</u> , to <u>7/23</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>7/23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Anne E. Greene</u>				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/24/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anne E. Greene				22e. ADDRESS JOHNS HOPKINS HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7/27/87		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.				
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, INC. 3331 Brehms Lane, Balto. Md. 21213				25a. DATE RECD. BY REGISTRAR JUL 24 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Darden-Randall</u>				

RELEASED AS NON-MEDICAL - DR. GOLLIE PER MR. GREGORY 7/23/87

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in the funeral director's office 3 should be detached for use as the burial-transit permit. Then place in the container papers. Proper burial should be completed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "not at work", injury, or other traumatic event, the medical examiner will be notified.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

060002 JUL 27 01

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. 0320

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
GEORGE F. YEAKEL						X			7-24-87			19		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
MALE	W	12 22 96	91 YRS.			7-24-87			19			8:43a		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH		
MD			USA			WIDOWED			DIVORCED			Baltimore City		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			1319 Hillman Street			DISABLED								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MD						BALTIMORE			YES X NO			1319 HILLMAN STREET 21202		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
UNKNOWN			UNKNOWN			NO			212-07-6278			MARGARET YEAKEL 1319 HILLMAN STREET		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY: Hypertensive arteriosclerotic cardiovascular disease
IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b) DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Parkinson's disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE: Mario F. Golle, Jr. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 7-24-87
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION	COUNTY	STATE
BURIAL	7/29/87	MOUNT ZION	LANDSOWNE		MD
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR		
NAME <u>WM. C. MARCH F/H</u> ADDRESS <u>1101 E. NORTH AVE.</u>			25b. REGISTRAR'S SIGNATURE <u>Juan Davidson-Randall</u>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, REASONS SHOULD BE STATED. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE REGISTRAR. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. GIVE PAGE 6 TO THE REGISTRAR. GIVE PAGE 7 TO THE FUNERAL DIRECTOR. GIVE PAGE 8 TO THE REGISTRAR. GIVE PAGE 9 TO THE FUNERAL DIRECTOR. GIVE PAGE 10 TO THE REGISTRAR. GIVE PAGE 11 TO THE FUNERAL DIRECTOR. GIVE PAGE 12 TO THE REGISTRAR. GIVE PAGE 13 TO THE FUNERAL DIRECTOR. GIVE PAGE 14 TO THE REGISTRAR. GIVE PAGE 15 TO THE FUNERAL DIRECTOR. GIVE PAGE 16 TO THE REGISTRAR. GIVE PAGE 17 TO THE FUNERAL DIRECTOR. GIVE PAGE 18 TO THE REGISTRAR. GIVE PAGE 19 TO THE FUNERAL DIRECTOR. GIVE PAGE 20 TO THE REGISTRAR. GIVE PAGE 21 TO THE FUNERAL DIRECTOR. GIVE PAGE 22 TO THE REGISTRAR. GIVE PAGE 23 TO THE FUNERAL DIRECTOR. GIVE PAGE 24 TO THE REGISTRAR. GIVE PAGE 25 TO THE FUNERAL DIRECTOR. GIVE PAGE 26 TO THE REGISTRAR. GIVE PAGE 27 TO THE FUNERAL DIRECTOR. GIVE PAGE 28 TO THE REGISTRAR. GIVE PAGE 29 TO THE FUNERAL DIRECTOR. GIVE PAGE 30 TO THE REGISTRAR. GIVE PAGE 31 TO THE FUNERAL DIRECTOR. GIVE PAGE 32 TO THE REGISTRAR. GIVE PAGE 33 TO THE FUNERAL DIRECTOR. GIVE PAGE 34 TO THE REGISTRAR. GIVE PAGE 35 TO THE FUNERAL DIRECTOR. GIVE PAGE 36 TO THE REGISTRAR. GIVE PAGE 37 TO THE FUNERAL DIRECTOR. GIVE PAGE 38 TO THE REGISTRAR. GIVE PAGE 39 TO THE FUNERAL DIRECTOR. GIVE PAGE 40 TO THE REGISTRAR. GIVE PAGE 41 TO THE FUNERAL DIRECTOR. GIVE PAGE 42 TO THE REGISTRAR. GIVE PAGE 43 TO THE FUNERAL DIRECTOR. GIVE PAGE 44 TO THE REGISTRAR. GIVE PAGE 45 TO THE FUNERAL DIRECTOR. GIVE PAGE 46 TO THE REGISTRAR. GIVE PAGE 47 TO THE FUNERAL DIRECTOR. GIVE PAGE 48 TO THE REGISTRAR. GIVE PAGE 49 TO THE FUNERAL DIRECTOR. GIVE PAGE 50 TO THE REGISTRAR. GIVE PAGE 51 TO THE FUNERAL DIRECTOR. GIVE PAGE 52 TO THE REGISTRAR. GIVE PAGE 53 TO THE FUNERAL DIRECTOR. GIVE PAGE 54 TO THE REGISTRAR. GIVE PAGE 55 TO THE FUNERAL DIRECTOR. GIVE PAGE 56 TO THE REGISTRAR. GIVE PAGE 57 TO THE FUNERAL DIRECTOR. GIVE PAGE 58 TO THE REGISTRAR. GIVE PAGE 59 TO THE FUNERAL DIRECTOR. GIVE PAGE 60 TO THE REGISTRAR. GIVE PAGE 61 TO THE FUNERAL DIRECTOR. GIVE PAGE 62 TO THE REGISTRAR. GIVE PAGE 63 TO THE FUNERAL DIRECTOR. GIVE PAGE 64 TO THE REGISTRAR. GIVE PAGE 65 TO THE FUNERAL DIRECTOR. GIVE PAGE 66 TO THE REGISTRAR. GIVE PAGE 67 TO THE FUNERAL DIRECTOR. GIVE PAGE 68 TO THE REGISTRAR. GIVE PAGE 69 TO THE FUNERAL DIRECTOR. GIVE PAGE 70 TO THE REGISTRAR. GIVE PAGE 71 TO THE FUNERAL DIRECTOR. GIVE PAGE 72 TO THE REGISTRAR. GIVE PAGE 73 TO THE FUNERAL DIRECTOR. GIVE PAGE 74 TO THE REGISTRAR. GIVE PAGE 75 TO THE FUNERAL DIRECTOR. GIVE PAGE 76 TO THE REGISTRAR. GIVE PAGE 77 TO THE FUNERAL DIRECTOR. GIVE PAGE 78 TO THE REGISTRAR. GIVE PAGE 79 TO THE FUNERAL DIRECTOR. GIVE PAGE 80 TO THE REGISTRAR. GIVE PAGE 81 TO THE FUNERAL DIRECTOR. GIVE PAGE 82 TO THE REGISTRAR. GIVE PAGE 83 TO THE FUNERAL DIRECTOR. GIVE PAGE 84 TO THE REGISTRAR. GIVE PAGE 85 TO THE FUNERAL DIRECTOR. GIVE PAGE 86 TO THE REGISTRAR. GIVE PAGE 87 TO THE FUNERAL DIRECTOR. GIVE PAGE 88 TO THE REGISTRAR. GIVE PAGE 89 TO THE FUNERAL DIRECTOR. GIVE PAGE 90 TO THE REGISTRAR. GIVE PAGE 91 TO THE FUNERAL DIRECTOR. GIVE PAGE 92 TO THE REGISTRAR. GIVE PAGE 93 TO THE FUNERAL DIRECTOR. GIVE PAGE 94 TO THE REGISTRAR. GIVE PAGE 95 TO THE FUNERAL DIRECTOR. GIVE PAGE 96 TO THE REGISTRAR. GIVE PAGE 97 TO THE FUNERAL DIRECTOR. GIVE PAGE 98 TO THE REGISTRAR. GIVE PAGE 99 TO THE FUNERAL DIRECTOR. GIVE PAGE 100 TO THE REGISTRAR.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

061513 JUL 30 81



20% COTTON 6% DEX

WINTERFALL

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR
1- STATE
REGISTRAR

REG. NO.

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Lacey

Young

2a. DATE KNOWN
OF
DEATH ESTI-
MATED ☒ 7 24 19 87

MONTH DAY YEAR

2b. HOUR
M

3. SEX
M

4. RACE
W

5. DATE OF BIRTH
MONTH DAY YEAR

10 9 16

6. AGE (IN YEARS
(LAST BIRTHDAY)

70 YRS.

IF UNDER 1 YR.
MONTHS DAYS

IF UNDER 24 HRS.
HOURS MIN

7c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR

2d. HOUR
M

7 26 19 87

8:58
P M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

W. VA.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City

MD.

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

279 S. Spring Ct.

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

SECURITY GUARD

12b. KIND OF BUSINESS
OR INDUSTRY

13a. STATE

MD.

13b. COUNTY

13c. CITY OR TOWN

BALTO.

13d. INSIDE CITY LIMITS?
YES ☐ NO ☐

13e. STREET ADDRESS

279 S. SPRING CT.

21231

14. FATHER'S NAME
FIRST MIDDLE LAST

15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

YES

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

1939 - 1954

17. INFORMANT

ADDRESS

Officer Lamont West - B.P.D.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?
Head & Abdom.
YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE Margarita A. Korell

TITLE (SPECIFY)

Assistant

MEDICAL EXAMINER

DATE SIGNED 7-27-87

EXAMINER'S NAME
(TYPE OR PRINT)

Margarita A. Korell, M.D.

ADDRESS 111 Penn St., Balto. Md. 21201

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

REMOVAL

23b. DATE

7-31-87

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION
CITY OR TOWN

COUNTY STATE

24. FUNERAL DIRECTOR
NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

State Anatomy Board Balto., Md.

AUG 10 1987

Margarita A. Korell

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/BA
25M

BP

DHMH - 17
(VR A15 ME (5))

085312 2011 08

30% COTTON FIBER

WINTERHILL

061383 JUL 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 20322

1 - FOR
STATE
REGISTRAR

REG. NO.

DECEASED NAME (PRINT) FIRST MIDDLE LAST TYESHA YOUNG		2a. DATE OF DEATH MONTH DAY YEAR JUNE 30, 1987		2b. HOUR MIN. 11:52 PM	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 06-30-87		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 2 0 48	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION JOHN HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST KEVIN YOUNG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PAULETTE RUSSELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS PAULETTE RUSSELL (SAME)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2hr 48min</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>extreme prematurity</u> <u>2hr 48min</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9:41pm 6-30</u> , 19 <u>87</u> , to <u>11:52 6-30</u> , 19 <u>87</u> , that (I) <u>(we)</u> <u>(saw)</u> <u>(did not)</u> view the body after death.					
22b. SIGNATURE <u>Elizabeth Carson Engle</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>7-1-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Elizabeth Carson Engle</u>		22e. ADDRESS <u>John Hopkins Dept. Pediatrics</u> <u>600 N. WOLFE ST. 21205</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE <u>7-1-87</u>	23c. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR <u>JUL 29 1987</u>	25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>

061383 JUL 30 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			
FOR STATE REGISTRAR			
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH	
FIRST MIDDLE LAST Joanna Veronica Yuhas		MONTH DAY YEAR 7/13/87	
3. SEX Female		4. AGE (IN YEARS LAST BIRTHDAY)	
5. RACE White		65 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		8. CITIZEN OF WHAT COUNTRY? USA	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		10. CITIZEN OF WHAT COUNTRY? USA	
11. CITY OR TOWN OF DEATH Baltimore		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		14. COUNTY Baltimore	
15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16. STREET ADDRESS / ZIP CODE 5408 Mayview Avenue 21206	
17. FATHER'S NAME Henry Wojtas		18. MOTHER'S MAIDEN NAME Mary Krusniak	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		20. SOCIAL SECURITY NO. 216-12-9651	
21. INFORMANT Mr. Michael K. Yuhas Sr.		22. ADDRESS Same	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>END STAGE CARDIAC DISEASE.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY DISEASE.</u>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED	
26. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
28. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		29. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	
30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		31. LOCATION STREET CITY OR TOWN COUNTY STATE	
32. I certify that (1) this hospital attended the deceased from _____, 19____, to _____, 19____, that (1) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
33. SIGNATURE 		34. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
35. PHYSICIAN'S NAME (TYPE OR PRINT) Leonard J. Ruck		36. ADDRESS Union Mem Hosp.	
37. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		38. DATE July 17, 1987	
39. NAME OF CEMETERY OR CREMATORY Gdns. of Faith		40. LOCATION Baltimore Maryland	
41. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Maryland		42. DATE REC'D BY REGISTRAR JUL 15 1987	
43. REGISTRAR'S SIGNATURE Julia Davidson-Randall		44. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	

Jul 10 1967
Baltimore
Baltimore

July 17, 1967

Serial

Richard J. Back Inc. Baltimore, Maryland

St. Michael's Church St. 2000

210-12-3801

no

Notes

copy

Attorney

2000 Bayview Avenue 21000

x

Religious

MI.

When interest is paid

Homeowner

Interest

USA

CA.

Nov. 27, 1961

Write

Remain

Veronica

Y. 100

John

061571 AUG -4 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20324

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Theresa V. ZACHARKO			2a. DATE OF DEATH MONTH DAY YEAR July 27, 1987	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 7, 1906	6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN. 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3828 Hudson Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales	12b. KIND OF BUSINESS OR INDUSTRY W.T. Grant
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Myszkowski		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maryanne Bielkowski		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-05-0480	17. INFORMANT ADDRESS Richard Zarchko 3828 Hudson St. 21224		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Mukeshu Luhar</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mukeshu Luhar MD		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-31-87	23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk		25a. DATE REC'D. BY REGISTRAR JUL 31 1987		
25b. ADDRESS 7922 Wise Ave. Dundalk, MD 21222		25c. REGISTRAR'S SIGNATURE <i>Julia Gordon-Rudolph</i>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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JUL 31 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 20325

1. FOR
STATE
REGISTRARDECEASED NAME FIRST MIDDLE LAST
Rose Zaganas
2a. DATE OF DEATH MONTH DAY YEAR
July 15, 1987
2b. HOUR
5:35 PM3. SEX Female
4. RACE White
5. DATE OF BIRTH MONTH DAY YEAR
June 28, 1902
6. AGE (IN YEARS LAST BIRTHDAY) 85
IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH
Baltimore City MD.10. CITY OR TOWN OF DEATH Baltimore
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Maryland General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife
12b. KIND OF BUSINESS OR INDUSTRYUSUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland
13b. COUNTY
13c. CITY OR TOWN Baltimore
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS / ZIP CODE Sutton Place Apt. 1111 Park Ave. 2120114. FATHER'S NAME FIRST MIDDLE LAST
William Groh
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Dorothy Goldstein16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No
(IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO. 212-70-8862
17. INFORMANT ADDRESS
George Zaganas 523 Idlewild Rd. 2101418. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Failure
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATHDUE TO, OR AS A CONSEQUENCE OF
(b) Congestive Heart Failure, Chronic Renal Failure and Anemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Left Pleural Effusions and Diabetes Mellitus

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Congestive Heart Failure, Chronic Renal Failure and Anemia

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)21d. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE22a. I certify that ☒ (this hospital) attended the deceased from July 15, 1987, to July 15, 1987, that ☒ (we) lost saw the deceased alive on July 15, 1987, and that in ☒ (my) (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (we) (did) (did not) view the body after death.22b. SIGNATURE C. Ravi M.D.
DEGREE
ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED 7-15-8722d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Ravi, M.D.
22e. ADDRESS c/o Maryland General Hospital23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
23b. DATE 7-18-87
23c. NAME OF CEMETERY OR CREMATORY Greek Cemetery
23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Maryland24. FUNERAL DIRECTOR NAME ADDRESS
Leonard J. Ruck, Inc. Baltimore, Md.
25a. DATE REC'D. BY REGISTRAR JUL 16 1987
25b. REGISTRAR'S SIGNATURE Julia Davidson-Podaca

26822 JUL 17 1971

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FOR
STATE
REGISTRAR
AUG 11 1987STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 326

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
EDWARD A. ZERA			7 28 1987			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
MALE	WHITE	9 10 25	61 YRS.			8 3 1987	12:30 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
N.Y.		U.S.A.				Baltimore City MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		117 W. Saratoga St.			Custodian		Balto. Zoo	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		
Valentine Zera				Helena Siersztutwsk		117 W. Saratoga Street 21201		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO		092-18-9435		Wanda Veri 226 Bury Dr. N.Y. 13209				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?	
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE		8-4-87		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		MEDICAL EXAMINER				
Ann M. Dixon, M.D.		111 Penn St., Balto., MD 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Cremation		8/6/87		Security Process Crem.		Catonsville Baltimore Md.		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				AUG 07 1987		J. ...		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHREG. NO. 87 20327
20 DATE OF DEATH MONTH DAY YEAR 76 HOUR
July 16, 1987 8:15^A_M

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George F. Zielinski			2a. DATE OF DEATH MONTH DAY YEAR July 16, 1987		2b. HOUR 8:15 ^A _M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 22, 1923		6. AGE (IN YEARS (LAST BIRTHDAY)) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 22 S. Potomac Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipping Line		12b. KIND OF BUSINESS OR INDUSTRY Oper.-Distil.

13a. STATE Md.			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 22 S. Potomac Street. 21224
14. FATHER'S NAME FIRST MIDDLE LAST James W. Zielinski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora -- Szydowski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 217-18-2818		17. INFORMANT Wife: Mary Anna Zielinski 22 S. Potomac St.; Balto., Md. 21224		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>< 30 min</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>MEDICATION</u> <u>Serious cell carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 mo</u>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hypertension</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>May</u> 19 <u>87</u> to <u>July</u> 19 <u>87</u> , that (we) last saw the deceased alive on <u>July 15</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) <u>view the body after death.</u>			
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Simon V. Scam</u>		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7/20/87	23c. NAME OF CEMETERY OR CREMATORY Holly Hills Mem. Garden- Balto., Maryland	23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Maryland
24. FUNERAL DIRECTOR (NAME) John A. Moran, Inc. Funeral Home 3000 E. Baltimore St.; Balto., Md. 21224		25. DATE REC'D. BY REGISTRAR JUL 17 1987	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for statistical, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

20328

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sarah s. Zierler			2a. DATE OF DEATH MONTH DAY YEAR 7 19 87		2b. HOUR 1204 P.M.	
3. SEX F FEMALE		4. RACE W WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 24, 1907		
6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
9. BALTIMORE CITY OR COUNTY OF DEATH Balt. City MD.		10. CITY OR TOWN OF DEATH Balt. City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PIANIST		12b. KIND OF BUSINESS OR INDUSTRY MUSIC				
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3608 CROYDON RD. #21207				
14. FATHER'S NAME FIRST MIDDLE LAST NATHAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA SILVERSTEIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-01-2382		17. INFORMANT ADDRESS LEONARD STULMAN APT. G 2 TENTMILL LA. #21208		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) asystole DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Rick A Martinez MD				22c. DATE SIGNED 7-19-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rick A Martinez				22e. ADDRESS SINAI HOSP. - BALTO., MD 21215		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUL 21, 1987		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		
23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO. MD		23e. DATE JUL 24 1987		23f. REGISTRAR'S SIGNATURE Julia Borden-Randall		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised by page 4.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH13 FOR
STATE
REGISTRAR

REG. NO.

20329

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE J. ZUBRINITZ			2a. DATE OF DEATH MONTH DAY YEAR JULY 9, 1987		2b. HOUR M 2 03 29
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 9, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Middle River	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3 Honeycomb Rd. 21220
14. FATHER'S NAME FIRST MIDDLE LAST Edward Boring		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche McDowell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212 22 6745		17. INFORMANT George Zubrinitz ADDRESS 39 Honeycomb Rd. Baltimore, Md. 21220	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE OF: ISCHEMIC CARDIOMYOPATHY-END STAGE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RENAL FAILURE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JUNE 8 , 19 87 , to JULY 9 , 19 87 , that (I) (we) last saw the deceased alive on JULY 9 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Kenneth D. Byerly		DEGREE MD		22c. DATE SIGNED 7/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth D. Byerly, M.D.		22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, Md. 21231			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 7/11/87		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.					
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA		25a. DATE REC'D BY REGISTRAR 7/10/87		25b. REGISTRAR'S SIGNATURE Jana Warden	

BP

